HISTORY QUESTIONNAIRE

NAME _____ DATE _____

What is your principal reason for seeing the doctor? _____

_____

How long have you had this problem? _____

What other complaints do you have? _____

_____

_____

How were you referred? _____

By whom? _____

REVIEW BY SYSTEMS (Just check yes or no- Doctor will inquire about details later)

GENERAL SYMPTOMS

Do you "feel bad" in general; weak; or tired? . . . . . Yes ( ) No ( )
Have you lost your appetite? . . . . . Yes ( ) No ( )
Have you lost or gained weight? . . . . . Yes ( ) No ( )
Lost?_____ Amount _____ Gained ?_____ Amount _____
What do you usually weigh? _____ lbs. Approximate weight now _____
Do you feel feverish? Or actually run fever? . . . . . Yes ( ) No ( )
Do you get dizzy? . . . . . Yes ( ) No ( )
Do you have fainting spells? . . . . . Yes ( ) No ( )
Do you have skin troubles? . . . . . Yes ( ) No ( )
Do you have hay fever, sinus allergy, asthma, or skin allergy? . . . . . Yes ( ) No ( )
Have you noticed any swelling, or knot, anywhere about your neck, arms, armpits, breasts,
skin or anywhere else about your body? . . . . . Yes ( ) No ( )
If so, where? _____
Do your feet or ankles swell? . . . . . Yes ( ) No ( )

HEAD, EYES, EARS, NOSE, THROAT

Are you subject to headaches very often? . . . . . Yes ( ) No ( )
If so, are they severe, "sick headaches?" . . . . . Yes ( ) No ( )
What do you take for them? . . . . . Yes ( ) No ( )
Do you have "sinus trouble," or trouble with your nose? . . . . . Yes ( ) No ( )
Have you been hoarse lately? . . . . . Yes ( ) No ( )
Do you have trouble with vision, other than need for glasses? . . . . . Yes ( ) No ( )
Do you have trouble hearing? . . . . . Yes ( ) No ( )

CHEST

Do you have to cough very often? . . . . . Yes ( ) No ( )
If so, do you cough up any phlegm? . . . . . Yes ( ) No ( )
Have you ever coughed up any blood? . . . . . Yes ( ) No ( )
Does ordinary everyday activity make you short of breath? . . . . . Yes ( ) No ( )
Does active exercise make you unusually short of breath? . . . . . Yes ( ) No ( )
If so, is it getting worse lately? . . . . . Yes ( ) No ( )
Do you seem to have trouble getting a deep breath? . . . . . Yes ( ) No ( )
Do you prefer to sleep on more than one pillow? . . . . . Yes ( ) No ( )
Do you wheeze when you breathe, or have asthma? . . . . . Yes ( ) No ( )
Do you have pains in the front of your chest? . . . . . Yes ( ) No ( )
Does exertion bring on chest pain? . . . . . Yes ( ) No ( )
Or, do you get chest pains even at rest? . . . . . Yes ( ) No ( )
Does your heart ever beat rapidly, or "thump?" . . . . . Yes ( ) No ( )
Do you ever get blue in the face or lips? . . . . . Yes ( ) No ( )
Are you worried about your heart? . . . . . Yes ( ) No ( )
Has any doctor diagnosed you as having heart trouble? . . . . . Yes ( ) No ( )

DIGESTIVE SYSTEM

When you swallow, does food or liquid ever stop in your throat or esophagus? . . . . . Yes ( ) No ( )
Do you have much "gas?" . . . . . Yes ( ) No ( )
Does your stomach often swell or bloat? . . . . . Yes ( ) No ( )
Do you belch often? . . . . . Yes ( ) No ( )
Does acid come up and burn in your chest or throat? . . . . . Yes ( ) No ( )
Do you ever feel "sick to your stomach" or nauseated? . . . . . Yes ( ) No ( )
Do you ever vomit, or spit up food? . . . . . Yes ( ) No ( )
Do you get an actual pain in your abdomen? . . . . . Yes ( ) No ( )
Do you have "soreness," "heaviness," "aching," "gnawing,"
or other type of discomfort in your abdomen? . . . . . Yes ( ) No ( )
If you have any stomach discomfort, is it made worse by eating? . . . . . Yes ( ) No ( )
Or, made better by eating? . . . . . Yes ( ) No ( )
Is it made better by alkalies such as Alkaseltzer, Rolaids, Tums, etc.? . . . . . Yes ( ) No ( )
Are you often constipated? . . . . . Yes ( ) No ( )
Do you take laxatives or enemas often? . . . . . Yes ( ) No ( )
Do you have loose bowels, or diarrhea? . . . . . Yes ( ) No ( )
Do you have rectal pain, soreness, or hemorrhoids? . . . . . Yes ( ) No ( )
Do you ever pass blood from the rectum? . . . . . Yes ( ) No ( )
Do you ever pass black or "tarry" movements? . . . . . Yes ( ) No ( )
Do you have a rupture or hernia? . . . . . Yes ( ) No ( )
Have you ever had a colonoscopy? . . . . . Yes ( ) No ( )
If yes, when? _____

GENITO-URINARY

Do you have to urinate too often? . . . . . Yes ( ) No ( )
Do you have burning or pain on urinating? . . . . . Yes ( ) No ( )
Have you ever had infection, blood or pus in the urine? . . . . . Yes ( ) No ( )
Does your urinary flow seem too slow? . . . . . Yes ( ) No ( )
Have you any trouble stopping the urine flow, or leakage? . . . . . Yes ( ) No ( )
Do you have to awaken at night to urinate? . . . . . Yes ( ) No ( )
If so, how many times a night? _____
Are you having any sexual problems? . . . . . Yes ( ) No ( )
For males over 50, have you had a prostate exam? . . . . . Yes ( ) No ( )

BONES, JOINTS, MUSCLES

Do you have any back trouble? . . . . . Yes ( ) No ( )
Do you have rheumatism, arthritis, or pains in arms, legs, or joints? . . . . . Yes ( ) No ( )
Does strength in some of your muscles seem reduced? . . . . . Yes ( ) No ( )
Are any of your joints swollen or stiff? . . . . . Yes ( ) No ( )
Have you ever been treated for arthritis? . . . . . Yes ( ) No ( )

NERVOUS SYSTEM

Are you nervous, tense or easily upset? . . . . . Yes ( ) No ( )
Do you get "blue" or despondent? . . . . . Yes ( ) No ( )
Do you worry too much? . . . . . Yes ( ) No ( )
Are you worried about your health? . . . . . Yes ( ) No ( )
Are you worried about cancer? . . . . . Yes ( ) No ( )
Do you ever wish you would die? . . . . . Yes ( ) No ( )
Do you take tranquilizers or sleeping pills? . . . . . Yes ( ) No ( )

NEUROLOGY

Do you have headaches? . . . . . Yes ( ) No ( )
Do you have double vision or loss of vision? . . . . . Yes ( ) No ( )
Do you have slurred speech or inability to speak? . . . . . Yes ( ) No ( )
Do you have difficulty swallowing or chewing? . . . . . Yes ( ) No ( )
Do you have weakness or paralysis? . . . . . Yes ( ) No ( )
Do you have numbness, tingling or burning in your feet, hands, toes, or fingers? . . . . . Yes ( ) No ( )
Do you have loss of balance or dizziness? . . . . . Yes ( ) No ( )
Do you have epilepsy or loss of consciousness? . . . . . Yes ( ) No ( )
Have you had a stoke or transient ischemic attacks? . . . . . Yes ( ) No ( )
Do you have a tremor or muscle stiffness? . . . . . Yes ( ) No ( )
Do you have difficulty with memory? . . . . . Yes ( ) No ( )
Do you have neck or back pain? . . . . . Yes ( ) No ( )

SLEEP DISORDER

Do you awaken unrefreshed? . . . . . Yes ( ) No ( )
Do you snore or stop breathing in your sleep? . . . . . Yes ( ) No ( )
Do you walk or talk in your sleep? . . . . . Yes ( ) No ( )
Do you fall asleep easily in the daytime? . . . . . Yes ( ) No ( )
Do you have difficulty falling or staying asleep? . . . . . Yes ( ) No ( )
Do you have any unusual movements in your sleep? . . . . . Yes ( ) No ( )
Have you been injured or have you injured your bed partner at night? . . . . . Yes ( ) No ( )

MENSTRUAL HISTORY (Women)

How many times have you been pregnant? . . . . . Yes ( ) No ( )
Have you ever had a miscarriage? . . . . . Yes ( ) No ( )
If yes, how many? _____
When was your last menstrual period? . . . . . Yes ( ) No ( )
Are your menstrual periods irregular? . . . . . Yes ( ) No ( )
Menstruations occur every _____ days, last _____days.
Do you menstruate too heavily? . . . . . Yes ( ) No ( )
Do you have more than usual discharge between periods? . . . . . Yes ( ) No ( )
Do you have much pain with periods? . . . . . Yes ( ) No ( )
If you have stopped menstruating, at what age? . . . . . Yes ( ) No ( )
Do you have any menopausal symptoms? . . . . . Yes ( ) No ( )
Are you on birth control pills? . . . . . Yes ( ) No ( )

Have you had a vaginal examination and "PAP"smear in the past year? . . . . . Yes ( ) No ( )
Approximate date _____
Have you ever had a breast x-ray? (mammogram or xeromammogram) . . . . . Yes ( ) No ( )
Do you have a gynecologist or primary care doctor who does routine PAP test, etc.?. . . . . Yes ( ) No ( )

PAST HISTORY

When was your last physical examination? _____

Any abnormality found? _____

_____

What x-rays have been done and when? _____

_____

Results or diagnoses? _____

_____

Electrocardiograms? _____ When?_____ Results? _____

Other tests? _____

_____

List operations, if any:	Date	List past illnesses and injuries:	Date
1. _____	Yr.( )	1. _____	Yr.( )
2. _____	Yr.( )	2. _____	Yr.( )
3. _____	Yr.( )	3. _____	Yr.( )
4. _____	Yr.( )	4. _____	Yr.( )

Have you had any blood transfusions? Yes ( ) No ( ) If yes, when? _____

Specifically, have you ever had:

Bronchial or lung trouble? . . . . . Yes ( ) No ( )
Tumor, growth or cancer? . . . . . Yes ( ) No ( )
Heart trouble? . . . . . Yes ( ) No ( )
High Blood Pressure?. . . . . Yes ( ) No ( )
Diabetes? (Or sugar in urine) . . . . . Yes ( ) No ( )
Nervous breakdown? . . . . . Yes ( ) No ( )
Rheumatic fever?. . . . . Yes ( ) No ( )
Kidney or bladder trouble? . . . . . Yes ( ) No ( )
Kidney Stones? . . . . . Yes ( ) No ( )
Stroke, Fits or Convulsion? . . . . . Yes ( ) No ( )
Gall bladder trouble? . . . . . Yes ( ) No ( )
Ulcer? . . . . . Yes ( ) No ( )
Jaundice or Hepatitis? . . . . . Yes ( ) No ( )
Prostate trouble? . . . . . Yes ( ) No ( )
Gonorrhea or Syphilis? . . . . . Yes ( ) No ( )
Gout? . . . . . Yes ( ) No ( )

Or have any of your family had:

Tuberculosis? . . . . . Yes ( ) No ( )
Tumor growth, or cancer? . . . . . Yes ( ) No ( )
Heart disease? . . . . . Yes ( ) No ( )
High Blood Pressure? . . . . . Yes ( ) No ( )
Stroke? . . . . . Yes ( ) No ( )
Diabetes? (Or sugar in urine) . . . . . Yes ( ) No ( )
Asthma, hay fever or allergy? . . . . . Yes ( ) No ( )
Nervous breakdown? . . . . . Yes ( ) No ( )
Gout? . . . . . Yes ( ) No ( )
Frequent sick headaches? . . . . . Yes ( ) No ( )
Any trouble similar to yours? . . . . . Yes ( ) No ( )
Epilepsy? . . . . . Yes ( ) No ( )
Colon or rectal cancer? . . . . . Yes ( ) No ( )
Colon or rectal polyps? . . . . . Yes ( ) No ( )
Breast Cancer? . . . . . Yes ( ) No ( )
Ovarian Cancer? . . . . . Yes ( ) No ( )

FAMILY

Father: Living? _____ Age? _____ Health? _____
Dead? _____ At Age? _____ Cause of Death? _____

Mother: Living? _____ Age? _____ Health? _____
Dead? _____ At Age? _____ Cause of Death? _____

Brothers: No. Living? _____ Health? _____
No. Dead? _____ Cause of Death? _____

Sisters: No. Living? _____ Health? _____
No. Dead? _____ Cause of Death? _____

Are you now married? Yes ( ) No ( ) If so, how many years? _____
Age of husband ( ) wife ( )
Is (wife) or (husband) in good health? Yes ( ) No ( )
Children? Number? _____ Ages? _____ Health? _____
Any dead? _____ Causes? _____

HABITS

Do you use tobacco? . . . . . Yes ( ) No ( )
Or have you ever used tobacco? . . . . . Yes ( ) No ( )
Cigarettes? _____ Cigars? _____ Pipe? _____ Smokeless tobacco? _____
Number per day _____
Drink coffee? . . . . . Yes ( ) No ( )
Number of cups per day _____
Drink any beverages with contain caffeine? . . . . . Yes ( ) No ( )
Amount per day _____
Drink beer, wine, liquor? . . . . . Yes ( ) No ( )
Number drinks per day _____ Week _____
Has drinking ever been a problem?. . . . . Yes ( ) No ( )
Have you ever had a drug problem or are you using drugs now?. . . . . Yes ( ) No ( )
Are you following any diet?. . . . . Yes ( ) No ( )
Type _____
Are you taking any medications? . . . . . Yes ( ) No ( )
List them: _____
_____
_____
_____
_____
Are there any medicines or drugs to which you are allergic, or have had bad effects on you? . . . . . Yes ( ) No ( )
List them: _____
_____

OCCUPATION

Do you work unusually hard, or long hours? . . . . . Yes ( ) No ( )
Is there much tension, pressure in your job? . . . . . Yes ( ) No ( )
Do you enjoy your job? . . . . . Yes ( ) No ( )