



Health History Questionnaire

Name: Last _____ First _____ MI _____ DOB: ___/___/___

Reason for Visit: _____ Age _____

Surgeries _____

Complications with surgeries:

Tobacco Use No Yes Quit: _____ How much: _____
 Alcohol No Yes less than 1/week 1-2/week 1-2/day >2/day
 Illicit Drug Use No Yes If yes which ones? _____

Occupation _____

Activities/sports _____

Family medical problems:

Mother _____

Father _____

Grandparents _____ Brothers/Sisters _____

Do you have any problems with your health listed below?

- Senses:** Eyes/vision Hearing Dizziness Loss of Balance
- General:** Fatigue Weight loss Weight gain Loss of appetite Fevers/chills
- GI:** Heartburn Diarrhea Constipation Nausea Eating disorder
- Circulatory:** Chest pain Palpitations Cold hands or feet Leg pain walking
 Swelling of legs Leg pain at night History of blood clot
- Lungs:** Shortness of breath Asthma Cough Sleep Apnea Bronchitis
- Nerves:** Burning/tingling/numbness in feet Muscle weakness Nerve problems
- Bone and Joint:** Joint pain Back pain Difficulty walking Gout
 Difficulty going up or down stairs Loose or unstable joints
- Skin:** Rash Dry/itching Nail problems Frequent wounds
- Immune system:** Frequent illness or infection Swollen joints or hands Night sweats
 Swollen lymph nodes Mouth sores Dry mouth/eyes Fever/chills

Height _____ Weight _____ Shoe size _____