



COMPLETE HEALTH HISTORY QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Sex:  Male  Female  
(Last) (First) (M.I.)

Age: \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
Month Day Year Cell Phone: (\_\_\_\_) \_\_\_\_\_

Physician Information:

Were you referred by a physician?  Yes  No  Self-referred  Other  
If yes, please complete the following:

Name of referring physician: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

List all other physicians you would like for us to keep informed of your overall health care:

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone/Area Code: \_\_\_\_\_ Fax: \_\_\_\_\_

Personal Information:

Marital Status:  Single  Married  Separated  Divorced  Widowed

Employment Status:

\_\_\_\_\_ Self-Employed \_\_\_\_\_ Employed by others \_\_\_\_\_ Student  
\_\_\_\_\_ Retired \_\_\_\_\_ Homemaker \_\_\_\_\_ Unemployed

If employed, please describe what type of work you do: \_\_\_\_\_

Do you live with  Spouse/family  Alone  With others

Social History:

Tobacco use:  None  Chew Tobacco  Cigar/Pipe  Cigarettes  
# of packs per day \_\_\_\_\_ How many years? \_\_\_\_\_ Quit date: \_\_\_\_\_

Alcohol use:  None Drinks per week \_\_\_\_\_  
Have you used alcohol in the past?  Yes  No Drinks per week \_\_\_\_\_ How many years? \_\_\_\_\_

Name: \_\_\_\_\_

MR# \_\_\_\_\_

**Family History:**

Family Members	Age	*Cancer History	Age Diagnosed	Cause of Death	General Health
Father					
Mother					
Brothers/Sisters					
Aunts/Cousins					
Children (indicate M/F)					

\* For family with cancer history, please specify what type and location of cancer

**Medical History:** (high blood pressure? diabetes? etc.) Please list all previous cancers you have had.

Medical Problem and Date Diagnosed

Medications for this problem

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Surgical History:** (List all previous surgeries)

Surgery and Date of Surgery

Name of Surgeon

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Current Medications: (if not listed under Medical History)**

Please list all the medications you are now taking. Please include aspirin, laxatives, nerve pills, birth control pills, vitamins, sleeping pills, etc., whether they are prescription or over-the-counter.

Please mark here if you have included an attached list ( )

<u>Name of Medication</u> ***	<u>Dose (mg)</u>	<u>Taken how many times per day?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

\*\*\*Please include the use of blood thinners (Warfarin, Coumadin, Plavix, Goody Powders, Aspirin)\*\*\*

Name: \_\_\_\_\_

MR# \_\_\_\_\_

**Allergies:**

Do you have any allergies?  Yes  No  **No known drug allergies**  
If yes, please list your allergy and describe the type of reaction you have:

<u>Medication</u>	<u>Type of Reaction</u>
_____	_____
_____	_____
_____	_____

<u>Other Allergies (food, dye, iodine)</u>	<u>Type of Reaction</u>
_____	_____
_____	_____

**Reproductive History:**

What was your age when you had your first period (menstruation)? \_\_\_\_\_  
What was the date of the first day of your last menstrual cycle? \_\_\_\_\_  
What is your current menstrual status?  Premenopausal  Ovaries removed  
 Peri-menopausal  Postmenopausal  Unknown  
Have you ever been pregnant?  Yes  No  
If "Yes," please enter the following information:

How many pregnancies: _____	Total premature births: _____
How many full term deliveries: _____	Total number of abortions: _____
Age at first live birth: _____	Total number of miscarriages: _____

Date of birth of each child:	Did you breast feed this child?
1. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please provide more detail about your use of hormones:

Oral contraceptive use:  Currently  Previously  Never  
 Number of years used: \_\_\_\_\_

Hormone replacement therapy use:

Estrogen/Premarin:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously <input type="checkbox"/> Unknown
Estrogen only:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously <input type="checkbox"/> Unknown
Progesterone only:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously <input type="checkbox"/> Unknown
Patch or topical/vaginal creams:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously <input type="checkbox"/> Unknown

Number of years used: \_\_\_\_\_

**Review of Systems: (Please check all that apply)**

<input type="checkbox"/> Recent weight loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Recent weight gain <input type="checkbox"/> Fevers/Chills <input type="checkbox"/> Poor appetite <input type="checkbox"/> Rashes/Sores <input type="checkbox"/> Hives/Itching (pruritis) <input type="checkbox"/> Vision changes <input type="checkbox"/> Glaucoma <input type="checkbox"/> Red, itchy eyes <input type="checkbox"/> Glasses, contacts <input type="checkbox"/> Cataracts <input type="checkbox"/> Hearing problems <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Dizziness (vertigo) <input type="checkbox"/> Frequent ear infections <input type="checkbox"/> Frequent colds <input type="checkbox"/> Sinusitis <input type="checkbox"/> Nosebleeds (epistaxis) <input type="checkbox"/> Nasal stuffiness <input type="checkbox"/> Dental problems <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Frequent sore throats <input type="checkbox"/> Hoarseness <input type="checkbox"/> Neck pain/stiffness <input type="checkbox"/> Swollen neck nodes <input type="checkbox"/> Enlarged thyroid <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Blood with cough (hemoptysis) <input type="checkbox"/> Chest pain or discomfort (angina) <input type="checkbox"/> High blood pressure <input type="checkbox"/> Blood clots <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Shortness of breath at rest (dyspnea) <input type="checkbox"/> Shortness of breath on exertion <input type="checkbox"/> Need to sleep upright (orthopnea) <input type="checkbox"/> Swelling in legs (edema) <input type="checkbox"/> Nausea <input type="checkbox"/> Reflux/GERD <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation	<input type="checkbox"/> Change in bowels <input type="checkbox"/> Black tarry stool (melena) <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Blood in stool (hematochezia) <input type="checkbox"/> Liver problems <input type="checkbox"/> Trouble swallowing (dysphagia) <input type="checkbox"/> Throwing up blood (hematemesis) <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Frequent urination <input type="checkbox"/> Incontinence <input type="checkbox"/> Burning or pain while urinating <input type="checkbox"/> Blood in urine (hematuria) <input type="checkbox"/> Frequent urinary tract infections <input type="checkbox"/> Kidney stones <input type="checkbox"/> Muscle pain <input type="checkbox"/> Back pain <input type="checkbox"/> Joint pain <input type="checkbox"/> Arthritis <input type="checkbox"/> Limited range of motion <input type="checkbox"/> Increased anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Mental illness <input type="checkbox"/> Mood swings <input type="checkbox"/> Leg cramps <input type="checkbox"/> Tingling in arms or legs <input type="checkbox"/> Tremors <input type="checkbox"/> Numbness <input type="checkbox"/> Memory Loss <input type="checkbox"/> Seizures <input type="checkbox"/> Headaches <input type="checkbox"/> Involuntary movements <input type="checkbox"/> Anemia <input type="checkbox"/> Swollen glands <input type="checkbox"/> Easy bruising or bleeding <input type="checkbox"/> Previous blood transfusion <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Fainting (syncope) <input type="checkbox"/> Steroid use <input type="checkbox"/> Excessive urination <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Diabetes <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Lupus <input type="checkbox"/> Other: _____    
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Name: \_\_\_\_\_

MR# \_\_\_\_\_

**Cancer Screening Questionnaire**

**Breast:**

Have you had your first screening bilateral mammogram?  Yes  No

If yes, at what age did you have your first screening mammogram? \_\_\_\_\_

When was your last breast mammogram, ultrasound or MRI? \_\_\_\_\_

Were there any abnormalities found on any of these exams or tests?  Yes  No

If yes, what was found? \_\_\_\_\_

Do you have any family history of breast or ovarian cancer? (if yes, please list whom and at what age)

\_\_\_\_\_  
\_\_\_\_\_

**Colon or Rectal:**

Have you had ever had a full colonoscopy for screening of colon or rectal cancer?  Yes  No

If yes, when was the most recent exam performed? \_\_\_\_\_

Have you ever had any other screening test such as stool for blood, flexible sigmoidoscopy or barium enema?

Yes  No If so, when? \_\_\_\_\_

Were there any abnormalities found on any of these exams or tests?  Yes  No

If yes, what was found? \_\_\_\_\_

Do you have any family history of colon or rectal cancer? (if yes, please list whom and at what age)

\_\_\_\_\_  
\_\_\_\_\_

**Prostate:**

Have you ever had a digital rectal exam to examine your prostate?  Yes  No

If yes, when was your last exam performed? \_\_\_\_\_

Have you ever had your blood drawn for a PSA level?  Yes  No

If yes, when was your last PSA level checked? \_\_\_\_\_

Were there any abnormalities found on any of these exams or tests?  Yes  No

If yes, what was found? \_\_\_\_\_

Do you have any family history of prostate cancer? (if yes, please list whom and at what age)

\_\_\_\_\_  
\_\_\_\_\_

**Testicular:**

Have you examined your testicles for abnormal lumps, masses or growths?  Yes  No

If yes, when did you perform the last exam? \_\_\_\_\_

Were there any abnormalities found on any of these exams?  Yes  No

If yes, what was found? \_\_\_\_\_

Do you have any family history of testicular cancer? (if yes, please list whom and at what age)

\_\_\_\_\_  
\_\_\_\_\_

**Cervix:**

Have you had your yearly PAP smear performed?  Yes  No

If yes, when was it done? \_\_\_\_\_

Were there any abnormalities found?  Yes  No

If yes, what was found? \_\_\_\_\_

Do you have any family history of cervical or endometrial cancer (if yes, please list whom and at what age)

\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

MR# \_\_\_\_\_

**Skin:**

Have you had a full body, naked skin examination within the last year?  Yes  No

Do you have a regular doctor who performs full body skin exams on you?  Yes  No

If yes, when was the most recent exam performed? \_\_\_\_\_

Did you have more than 2 sunburns before the age of 18?  Yes  No

Do you have  brown hair?  brown eyes  blond hair  red hair  blue/green/hazel eyes  
 >50 moles on your body  freckling  fair complexion

Do you use sunscreen when outdoors?  Always  Sometimes  Rarely  Never

Do you put sunscreen on your children when outdoors?  Always  Sometimes  Rarely  Never

Have you ever used a sunlamp or tanning booth/salon?  Regularly  Sometimes  Rarely  Never

If yes, how often and at what age did/do you do so? \_\_\_\_\_

Have you ever had a skin lesion frozen?  Yes  No If yes, has the lesion returned?  Yes  No

Have you ever had a biopsy of a skin lesion?  Yes  No

Have any abnormalities ever been found on any of these skin tests?  Yes  No

If yes, what was found? \_\_\_\_\_

Do you have any family history of skin cancer (melanoma, basal cell, squamous cell)? If yes, please list whom and at what age: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please list any other questions or concerns that we can help you with on this visit: (We appreciate you taking the time to fill out this form. Thank you!)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reviewed by: _____ R.N.    Reviewed by: _____ M.D./PA-C (For office use only)
----------------------------------------------------------------------------------