Patient Name: ____ DOB: __________________Today's Date: _________________

Please help us help you by answering this health assessment questionnaire completely and honestly.

PERSONAL MEDICAL HISTORY (√ all that apply: give any details, date or age at diagnosis or onset, if known)

Hospitalizations: __Yes __No (if yes, complete the information below. If more than 4 hospital stays, use last page of questionnaire)

	Reason	Date	Length of stay
#1:	______________________________	__________________	_________________
#2:	______________________________	__________________	_________________
#3:	______________________________	__________________	_________________
#4:	______________________________	__________________	_________________

Additional hospitalization information:____

____

HEENT (head, eyes, ears, nose, throat)

__Cataracts______________ __Laryngomalacia(soft larynx)_________________ __Recurrent sinusitis_____________
__Cleft lip______________ __Macular degeneration_____________ __Tracheomalacia(soft trachea)______________
__ Cleft palate___________ __Recurrent ear infections____________________ __Glaucoma__________________
__Other HEENT history____

ENDOCRINE

__Diabetes mellitus_______________ __Graves disease_______________ __Hypothyroidism (underactive)_______________
__Gestational onset DM_______________________ __Hyperthyroidism (overactive)______________________
__Other endocrine history____

RESPIRATORY

__Allergies/hay fever_________________ __C-PAP/BiPAP___________________ __Sleep apnea____________________
__Asthma_________________ __Pneumonia__________________ __COPD__________________
__Pulmonary embolism__________________ __Other respiratory history____

CARDIOVASCULAR

__Abd. aortic aneurysm______________ __Coronary artery disease_______________ __MI (heart attack)________________
__ Angina____________ __Deep venous thrombosis_______________ __Peripheral vascular dz_____________________
__Atrial fibrillation________________ __Heart failure_______________ __Pulmonary hypertension___________________
__Cardiac arrhythmias_________________ __Heart valve disease________________ __QTC prolongation_____________
__Carotid stenosis_____________ __Hyperlipidemia____________ __Venous insufficiency_______________________
__Congenital heart disease_____________________ __Hypertension________________________
__Other CV history____

GASTROINTESTINAL

__Chronic Constipation___________ __Hemorrhoids___________________ __Liver disease________________________
__Chronic Diarrhea_________________ __Hiatal hernia_________________ __Pancreatitis____________________
__Colitis____________________ __Inguinal hernia__________________ __Peptic ulcer disease________________________
__Diverticulosis_______________ __Irritable bowel syndrome_______________ __Umbilical hernia________________
__GERD________________ __ Jaundice_____________ __Other GI history____

GENITOURINARY

__Chlamydia__________________ __Hydronephrosis___________________ __Kidney stones______________________
__Decreased libido____________ __Kidney dialysis ____________ __Past urinary tract/bladder infections______________
__Gonorrhea_________________ __Kidney disease________________________ __Urinary incontinence__________________
__Herpes genitalis_____________ __Kidney Failure______________ __Human papilloma virus(HPV)_________________
__Other GU history____

MALE GENITOURINARY

__ BPH___________________ __Premature ejaculation____________________ __Testicular problems_______________
__Erectile dysfunction_______________ __Prostate problems_________________ __Undescended testicle_____________
__Other male GU problem____

FEMALE GYNECOLOGICAL

__Abnormal PAP____________ __Pelvic inflammatory disease (PID)_____________ __Recurrent vaginal infxn_______________
__Chronic pelvic pain_______________________ __Polycystic ovarian syndrome______________________
__Endometriosis______________________ __Other GYN history____

FEMALE REPRODUCTIVE HISTORY

Age at first period____ Age at menopause____ Pregnancy history: # of pregnancies____ # of births____# of live births______
Abortions: Miscarriages_____ Elective terminations____ Other pregnancy information______________________________

BREAST

__Benign cyst___________ __Fibroadenoma____________ __Fibrocystic breast dz___________ __Mastitis________________
__Other breast history____

Patient Name: ____________________ DOB: __________Today's Date: __________

PERSONAL MEDICAL HISTORY continued… (√ all that apply: give any details, date or age at diagnosis or onset, if known)

HEMATOLOGY

__Anemia__________ __Lupus anticoagulant__________ __Sickle cell dz__________
__Antithrombin deficiency__________ __MTHFR__________ __Thrombocytosis__________
__Chronic anticoagulation__________ __Protein C deficiency__________ __Transfusion__________
__Factor V Leiden__________ __Protein S deficiency__________
__Hemolytic uremia syndrome__________ __Prothrombin II mutation__________
__Other hematology history__________

MUSCULOSKELETAL

__Arthritis__________ __Fractures__________ __Osteoporosis__________
__Carpal tunnel__________ __Gout__________ __Spinal stenosis__________
__Cervical disk disease__________ __Lumbar disk disease__________ __Osteopenia__________
__Degenerative joint dz__________ __Other musculoskeletal history__________

RHEUMATOLOGIC

__Fibromyalgia__________ __Osteoarthritis__________ __Sjogren's syndrome __________
__Lupus__________ __Rheumatoid arthritis__________
__Other autoimmune disorder__________ __________

CANCER

__Blood__________ __GU__________ __Neurologic__________ __Brain__________ __Kidney__________
__Oral__________ __Breast__________ __Leukemia__________ __Skin__________
__Colorectal__________ __Liver__________ __Stomach__________ __Endocrine__________ __Lung__________
__Thyroid__________ __Eye__________ __Lymphoma__________ __GI__________
__Musculoskeletal__________ __Other cancer history__________

MALE CANCER

__Prostate__________ __Testicular__________ __Other __________

FEMALE CANCER

__Cervical__________ __Ovarian__________ __Uterine__________ __Other__________

INFECTIOUS DISEASE

__AIDS__________ __MRSA__________ __Syphilis__________ __Chickenpox__________
__Mumps__________ __Tuberculosis__________ __Hepatitis__________ __Polio__________
__Vanc-resistant enterococci__________ __HIV__________ __Positive PPD__________ __West Nile__________
__Measles__________ __Rheumatic fever__________ __Meningitis__________ __Rubella__________
__Other infectious disease history__________

INTEGUMENTARY (skin, hair, nails)

__Acne__________ __Psoriasis__________ __Eczema__________
__Other integumentary history__________

NEUROLOGIC

__Cerebral Aneurysm__________ __Hydrocephalus__________ __Restless leg syndrome__________
__Cerebral palsy__________ __Insomnia__________ __Seizures__________
__Coma__________ __Intra-cranial bleeding__________ __Stroke__________
__Concussion__________ __Mental retardation__________ __Traumatic brain injury (TBI)__________
__Dementia__________ __Multiple sclerosis__________ __Transient ischemic attack (TIA)__________
__Developmental delay__________ __Narcolepsy__________ __Tremors__________
__Fetal alcohol syndrome__________ __Parkinson's dz__________ __Peripheral neuropathy__________
__Headaches__________ __Other neurological history__________

PSYCHIATRIC

__Addiction__________ __Bulimia__________ __Panic disorder__________
__ADD__________ __Cyclothymic__________ __Pervasive development DO__________
__ADHD__________ __Depression__________ __Psychosis__________
__Anorexia nervosa__________ __Dysthymic__________ __PTSD__________
__Anxiety__________ __ECT treatment__________ __Social anxiety__________
__Asperger's disorder__________ __Homicidal ideation__________ __Schizoaffective disorder__________
__Autism__________ __Learning problems__________ __Schizophrenia__________
__Behavior problems__________ __Mood disorders__________ __Suicidality__________
__Bipolar disorder__________ __OCD__________ __Other psychiatric history__________
__Psychiatric Treatment__________

Patient Name: ____ DOB: __________________Today's Date: _________________

PERSONAL MEDICAL HISTORY continued… (√ all that apply: give any details, date or age at diagnosis or onset, if known)

GENETIC/METABOLIC
__Birth defects_________________ __Cystic fibrosis________________ __Chromosomal disorder_________________
__Down syndrome______________ __Congenital deformity________________ __Obesity_______________
__Other genetic history______________________________ __Other metabolic history________________________________

EVENTS
__Anaphylaxis_______________ __Motor vehicle accident________________ __Gunshot wound__________________
__Other events____

DISABILITIES
__Hearing deficit___________ __Vision deficit_________ __Paraplegia______________ __Quadriplegia_______________
__Hemiparesis: __right __left __Other disabilities____

PAST SURGICAL HISTORY (√ all that apply: give any details, date or age at the time of the procedure, if known)
SURGICAL HISTORY: __Yes __No (if none, skip to FAMILY MEDICAL HISTORY section)

HEENT (head, eyes, ears, nose, throat)
__Adenoidectomy_________________ __Dental surgery________________ __Cataract extraction_________________
__Laryngectomy_________________ __Tonsillectomy_________________ __Cleft lip repair_______________
__Cleft palate repair______________ __Other HEENT surgery(s)____

ENDOCRINE
__Parathyroidectomy_______________________ __Thyroid surgery________________________
__Other endocrine surgery____

RESPIRATORY
__Bronchoscopy____________ __Lobectomy______________ __Other chest surgery________________________________

CARDIOVASCULAR
__Angiogram__________________ __Congenital defect repair___________________ __Pacemaker___________________
__Angioplasty___________________ __Coronary stent______________ __Valve replacement__________________
__CABG (bypass)__________________ __Heart transplant_____________________ __Carotid endarterectomy_______________
__Other CV surgery____

GASTROINTESTINAL
__Appendectomy_________________ __Gastric bypass__________________ __Splenectomy___________________
__Cholecystectomy(gallbladder)____________ __Hemorrhoidectomy_________ __Umbilical hernia repair____________
__Colectomy_______________ __Inguinal hernia repair__________________ __Endoscopy_______________________________
__Other GI surgery____

GENITOURINARY
__Bladder surgery______________ __Nephrectomy (kidney removal)______________ __Kidney stone extraction_____________
__Other GU surgery____

MALE GENITOURINARY
__Prostatectomy___________________ __TURP____________________ __Vasectomy____________________
__Other male GU surgery____

FEMALE GYNECOLOGIC
__Cervical conization/LEEP__________________ __Hysterectomy_________________ __Pelvic support surgery______________
__Cervical surgery________________ __Hysteroscopy________________ __Tubal surgery__________________________
__Caesarian delivery______________ __Myomectomy________________ __Vulvar surgery__________________________
__Ablation____________________ __Oophorectomy________________ __D&C______________________
__Ovarian surgery________________________ __Other GYN surgery____

MUSCULOSKELETAL
__Arthroscopy_______________________________ __Joint replacement_____________________________________
__Fractures repair_____________________________ __Other musculoskeletal surg______________________________

INTEGUMENTARY (skin, hair, nails)
__Skin cancer removal_____________________________ __Plastic surgery_______________________________________
__Other integumentary surgery____

NEUROLOGIC
__Craniotomy__________________ __VP shunt placement_________________ __VP shunt revision__________________
__Spinal surgery____________________ __Other neurologic surgery____

BREAST
__Breast augmentation________________ __Lumpectomy_________________ __Mastectomy___________________
__Breast biopsy_____________________ __Other breast surgery____

Patient Name: ____ DOB: __________________Today's Date: _________________

FAMILY MEDICAL HISTORY (√ if any BLOOD relatives have had any of the following conditions AND indicate relationship)

__Diabetes_________________________ __Lung cancer________________________ __Drug abuse___________________
__Thyroid disease__________________ __Ovarian cancer_______________________ __Mental illness_________________
__Asthma__________________________ __Prostate cancer______________________ __Autoimmune dz______________
__Hyperlipidemia__________________ __Other cancer________________________ __Blood disorders______________
__Hypertension___________________ __Hepatitis B__________________________ __Rheumatoid dz_______________
__Atherosclerosis__________________ __Tuberculosis________________________ __Hearing problems_____________
__Coronary artery dz_______________ __Dementia____________________________ __Vision problems______________
__Other heart disorders_____________ __Stroke______________________________ __Obesity_____________________
__Kidney disease__________________ __Alcoholism__________________________ __Other______________________
__Breast cancer___________________ __Depression__________________________ __No history available____________
__Colorectal cancer________________ __ Additional family history____

SOCIAL HISTORY (Please answer the following questions regarding your health and habits)

Educational level____
Foster care: __Yes __No If yes, please provide history____
Household members____
Leisure activities____
Marital status____
Military service: __Yes __No Comments____
Occupation____
Occupational exposures: __Yes __No If yes, explain:____
Pets: __Yes __No Comments____
Relationships____
Sexual history____
Travel history________________________ International? __Yes __No If yes, where?_________________________________
Additional Social History Info:____
Abuse history: __None __Emotional/verbal __Physical __Sexual __Other abuse history________________________________
Gambling history: __None __Casino __Internet gambling __Sports __Video lottery
Internet use: __None __0-2 hrs/day __2-4 hrs/day __4-6 hrs/day __More than 6 hrs/day __Other: ___hrs per ___
Purpose: __Gaming __Networking __Porn __Social __Work __School __Other_________________________

DIETARY HABITS

Well-balanced diet: __Daily or most days __About ½ the time __Rarely or never __Other: explain _________________
High-fat food intake: __0-1 times/day __2 times/day __3 or more times/day __Other: explain______________________
Daily servings of fruit/vegetables: __0-1 __2-4 __5 or more __Other: explain______________________________________
Daily servings of milk/calcium: __0-1 __2-3 __4 or more __Other: explain____
Eating out: __Rarely or never __1-3 times/week __4 or more times/week __Other: explain_______________________
Read food labels: __Usually or always __Sometimes __Seldom or never __Other: explain____________________
Weight described as: __0-5 lbs over __6-15 lbs over __More than 15 lbs over __0-5 lbs under __6-15 lbs under
__More than 16 lbs under In the past year, weight has: __Remained stable __↑10 lbs or more __↓10 lbs or more

EXERCISE/PHYSICAL ACTIVITY

__None __Walking __Running __Bicycling __Swimming __Yoga __Aerobics __Weight training __Other_________
Frequency: __1-2 times/week __3-4 times/week __ 5-6 times/week __Daily __Other___________________________
Duration per day: __less than 15 minutes __15-30 minutes __31-45 minutes __46-60 minutes __61-90 minutes
__more than 90 minutes __Other: explain____

TOBACCO USE

__Current every day smoker __Current some day smoker __Former smoker __Never smoker __Smokeless tobacco user
If current or former smoker, how much? _____cigarettes per day (1 pack=20 cigarettes) How long? _____years
Does anyone in your home smoke? __Yes __No

ALCOHOL USE/INTAKE

__None __1-2 drinks/day __3 or more drinks/day __1-2 drinks/week __1-2 drinks/month __Other___drinks per_____

CAFFEINE USE/INTAKE

__None __1-2 beverages/day __3 or more beverages/day __Other _____ beverages per ______

SUBSTANCE USE

__None __Hallucinogens __Club/designer drugs __Marijuana __Tranquilizers/sedatives __Inhalants
__Cocaine/crack __Opiates __Injection drugs __Amphetamines __Painkillers __Other____________

Patient Name: ____ DOB: _________________Today's Date: ________________

SOCIAL HISTORY continued… (Please answer the following questions regarding your health and habits)

FAITH/RELIGION
__Christianity __Buddhism __Judaism __Hinduism __Islam __Alternative faith __Other_______________
Special faith needs: __Yes __No If yes, explain:____

VEHICLE SAFETY
Seatbelt use: __Always __Sometimes __Never __Other____
Helmet use: __Always __Sometimes __Never __Other____
Drive intoxicated or ride with intoxicated driver: __Never __Rarely __Weekly __Daily __Other___________________

HOME /PERSONAL SAFETY
Water heater temp ↓ 120°F: __Yes __No
Working smoke detector in home: __Yes __No
Fire extinguisher in home: __Yes __No
Carbon monoxide detector in home: __Yes __No
Firearms in home: __Yes __No
If yes, unloaded? __Yes __No
locked? __Yes __No
Caregiver needed: __Yes __No

Please write anything you feel is important for us to know in providing your health care needs that is not addressed in this questionnaire:

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