

Name: _____

Health History Questionnaire
Please complete the following information as thoroughly as possible. Thank You

Past Medical History

Please list any medical problems you have been diagnosed with or treated for:

Past Surgical History:

Please list all surgeries you have had including the dates:

_____	Date
_____	Date
_____	Date
_____	Date

Family History

Is your Father alive? Yes No Is your Mother alive? Yes No
Do you have Brothers? Yes No Do you have Sisters? Yes No
Do/Did any of your family members have a history of prostate, kidney, or bladder problems? Yes No
If yes, what type of problem and of whom? _____

Social History

Are you married? Yes No Do you have children? Yes No
Do you work or what type of work are you retired from? Yes No Type: _____

Current Medications and Vitamins

Name	Strength (mg)	How often?

Do you have any medication allergies? Yes No
(If yes, please list allergies including their side affects)

Name: _____

Please circle any symptoms, which you frequently experience:**SYMPTOMS**

General: fatigue, tiredness, fever, weight loss

Eyes: blurring, double vision, irritation, discharge

Ear/Nose/Throat: ear pain or discharge, nasal obstruction or discharge, sore throat

Cardiovascular: chest pain, palpitations, difficulty breathing when lying down, swelling of legs

Respiratory: coughing, wheezing, shortness of breath, blood in sputum

Gastrointestinal: abdominal pain, difficulty swallowing, nausea, vomiting, diarrhea, constipation

Genitourinary: blood in urine, urinating frequently, urine leakage, pain with urination, erection difficulty

Musculoskeletal: back pain, joint swelling, joint stiffness, joint pain

Skin: rashes, itching, lumps, sores, color change

Neurologic: fainting, lightheadedness, seizures, transient paralysis, numbness, headaches

Psychiatric: depression, anxiety, difficulty sleeping

Endocrine: excessive thirst, recent weight loss or gain, heat intolerance, cold intolerance

Heme/Lymphatic: easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, swollen glands

Allergic/Immunologic: hives, hay fever, recurrent or frequent infections

Risk Factors

Do you smoke? Current Previously Never

(If current or previous, please answer the following)

Year started? _____ How many packs per day? _____ How many years? _____

(If previous, please answer the following)

Were you counseled to quit/cut down? Yes No If yes, when? _____

Do you consume alcoholic beverages? Yes No

If yes, how many drinks per day? _____ Per week? _____ Per month? _____

Type of alcohol? _____

Do you consume any caffeine on a daily basis? Yes No

If yes, how many cups per day? _____

Do you follow a regular exercise program weekly? Yes No How many days a week? _____

If yes, what type of exercise? (*walk, weights, etc.*) _____