Health History Questionnaire

Date: ____________

Patient Name: _______________________________ DOB: ________________________

List any **current** medical conditions you have (i.e. diabetes, high blood pressure etc.):

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

List any **past** medical conditions and associated hospitalizations (i.e. pneumonia, hospitalized 2/84):

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

List **all** surgeries with dates:

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

List all **current prescription medications** w/dosage and frequency you take:

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

List all **current over the counter medications** (including vitamins and supplements) you are take:

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

List **all** drug allergies (both prescription and over the counter):

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

Has anyone in your immediate family been diagnosed with any of the following diseases? If yes, please specify age of diagnosis.

No	Yes	
❑	❑	Cardiovascular Disease _______________________________
❑	❑	Diabetes _______________________________
❑	❑	Colon Cancer _______________________________
❑	❑	Breast Cancer _______________________________
❑	❑	Prostate Cancer _______________________________
❑	❑	Skin Cancer _______________________________
❑	❑	Other: _______________________________

What has been your occupation over the last 10 years?

____

____

____

Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Widow ❑ Single

Number of Children: ___________

Have you ever smoked cigarettes, cigars or pipes: Y/N
How many years? _________ Have you quit? Y/N If so, when? _________

Have you ever used recreational drugs? _________________ If so, when? _________________

Do you drink alcohol? Y/N
How many drinks do you have in a week? (1 drink is equal to: 4oz. wine, 12 oz. beer, 1 oz. liquor)

- ❑ Less than two a week

- ❑ 2-5 per week
- ❑ 6-14 per week
- ❑ 14 or more per week

The following list is designed to reveal symptoms of aging and early manifestations of disease you may not have recognized. Please check each box that currently applies or has applied to you.

General Health

- ❑ More tired than you would like to be on a daily basis
- ❑ Recently depressed
- ❑ Lost interest in life
- ❑ Anxious on a regular basis
- ❑ Sleep 7 or more hours per night
- ❑ Sleep less than 7 hours per night
- ❑ Loss of ambition
- ❑ Loss of determination
- ❑ Loss of optimism

Cardiopulmonary

- ❑ Chest pain at rest
- ❑ Chest pain with exertion
- ❑ Irregular heart beat
- ❑ Shortness of breath with exertion
- ❑ Shortness of breath when you lie flat on your back
- ❑ Ankles swell significantly if you stand or walk for a long time
- ❑ Calves burn if you walk more than a short distance
- ❑ Appears as if a shade were being pulled over either or both eyes for a short time
- ❑ Wheezing

Gastrointestinal

- ❑ Frequent heartburn
- ❑ Take antacids frequently
- ❑ Burning in your stomach if you haven't eaten for a while
- ❑ Vomited up blood or coffee ground appearing material
- ❑ Sense of being full before eating much of a meal
- ❑ Milk products cause bloating, belching or gas
- ❑ Take lactose intolerance aids regularly
- ❑ Frequent constipation
- ❑ Loose stools regularly
- ❑ Blood in your stools
- ❑ Hemorrhoids
- ❑ Abdominal cramping regularly when eating
- ❑ Feeling weak or breaking into a sweat a few hours after eating
- ❑ Trouble swallowing

Neurological

- Tingling of hands or feet
- Intermittent weakness of extremities
- Frequent headaches
- Dizziness if you turn your head quickly
- Difficulty talking distinctly
- Tremor or shaking of hands
- Inability to remember things

Musculoskeletal

- Frequent aching of joints
- Frequent swelling of joints
- Frequent back pain
- Frequent neck pain
- Decrease in muscle tone/size in the past year
- Aching in feet or heels when you take your first steps in the morning

Endocrine

- Sensitivity to heat or cold
- Weight loss of 10 lbs. or more in the past 6 months
- Weight gain of 10 lbs. or more in the past 6 months
- No weight fluctuation in the last 5 years
- Increase in fat around your waist in the last 5 years

Skin

- Dry skin regularly
- Dry skin in winter only
- Frequent pimples or acne
- Wrinkling of skin in the past year
- Bruise easily
- Rashes
- Itching
- Dry hair
- Oily hair
- Recent rapid hair loss

Men Only

- Decreased libido (sex drive)
- Lack of energy
- Decrease in strength and/or endurance
- Height loss
- Decreased "enjoyment of life"
- Sad or grumpy
- Erections less strong
- Deterioration in ability to play sports
- Falling asleep after dinner
- Deterioration in work performance

In the past month:

How often have you had the sensation of not emptying your bladder completely after urinating? ______________

How often have you had to urinate less than 2 hours after you have previously urinated? ______________

How often have you stopped and started again several times during urination? ______________

How often have you had a weak urinary stream? ______________

How often have you had to push or strain to begin urination? ______________

How many times do you get up to urinate during the night? ______________

Women Only

What was the date of your last period? ______________

What was the date of the period before the last? ______________

At what age did you start menstruating? ______________

How many days is it between your periods? ______________

How many days of flow do you have during your periods? ______________

How many of these days would you say are "heavy"? ______________

Are your cycles regular? ______________

Do you suffer from PMS? ______________

How many periods have you missed in the last year? ______________

Do you experience?

- ❑ Breast tenderness at any time during your cycle? If so, when? _________________________________
- ❑ Bloating during your cycle? If so, when? ____
- ❑ Headaches during your cycle?
- ❑ Irritability/emotional during you're your cycle?
- ❑ Hot flashes
- ❑ Vaginal dryness
- ❑ Frequent painful intercourse
- ❑ Frequent yeast infections
- ❑ Frequent urinary tract (bladder) infections

On a scale of 1 to 10 (10 being the highest), how would you rate your sex drive? ______________

Has your sex drive changed significantly since you were younger? ______________

Has the quality, intensity or frequency of your orgasms changed? ______________

How many times have you been pregnant? ______________

How many pregnancies have resulted in live birth? ____________

What were your other pregnancy outcomes? ____________

Diagnostic Test Results

Please list the **most recent** results of the following tests (if you have copies of results please furnish):

Cholesterol ____________ HDL ____________ LDL ____________ Triglycerides ____________

PSA ____________ Date ____________

Mammogram	(circle one)	Normal	Abnormal	Date: ____________
Pap Smear	(circle one)	Normal	Abnormal	Date: ____________
Sigmoidoscopy	(circle one)	Normal	Abnormal	Date: ____________
Colonoscopy	(circle one)	Normal	Abnormal	Date: ____________
Stress Test	(circle one)	Normal	Abnormal	Date: ____________
Electron beam CT (Imatron scan)	(circle one)	Normal	Abnormal	Date: ____________
Bone Mineral Density Scan	(circle one)	Normal	Abnormal	Date: ____________

Exercise Assessment

Do you?

- ❑ Walk daily (circle one) Less than 20 min. 20-40 min. more than 40 min.
- ❑ Lift weights regularly If so, what is your routine? ____________________________________
- ❑ Cardio training If so, what is your routine? ____________________________________
- ❑ Regular athletic activity Is so, describe ____

24 Hour Diet Recall

Please list everything you have eaten in your last 3 meals, include snacks and beverages.

Breakfast:

____

____

Snack:

____

____

Lunch:

____

____

Snack:

____

____

Dinner:

____

____

Snack:

____

____