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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