CONFIDENTIAL

HEALTH HISTORY QUESTIONNAIRE

Name_____ **Today's Date**_____

PAST HEALTH HISTORIES

YOUR PAST HISTORY OF MEDICAL PROBLEMS, ILLNESSES, INJURIES, SURGERIES AND HOSPITALIZATIONS.

Please mark with an (X) any of the following illnesses and medical problems you have or have had and indicate the year when each started. If you are not certain when an illness started, written down an approximate year.

Illness	(X)	(Year)	Illness	(X)	(Year)	Illness	(X)	(Year)
Eye or eye lid infection			Diverticulosis			Cancer or tumor		
Glaucoma			Colitis			Anemia		
Cataracts			Other bowel problem			Bleeding tendency		
Other eye problems			Hepatitis			Blood transfusion		
Ear trouble			Liver trouble			Diabetes		
Deafness or decreased hearing			Gallbladder trouble			Endocrine		
Thyroid trouble			Hernia			Glandular trouble		
Strep throat			Hemorrhoids			Measles/Rubeola		
Bronchitis			Gynecological/Obstetrical			German Measles/Rubella		
Emphysema			Problems			Polio		
Pneumonia			Breast problems			Mumps		
Allergies			DES exposure			Scarlet fever		
Asthma			Kidney or bladder disease			Chicken pox		
Tuberculosis			Phlebitis/Varicose veins			Mononucleosis		
Other lung problems			Mental problems			Malaria		
High blood pressure			Nervous breakdown			Other tropical diseases		
Heart attack			Headaches			Condyloma (Warts)		
Arteriosclerosis			Head injury			Chlamydia		
(hardening of arteries)			Stroke			Genital herpes		
Heart murmur			Convulsions, seizures			Other venereal diseases		
Rheumatic fever			Arthritis			AIDS		
Other heart condition			Eczema			Other (explain on extra		
High cholesterol			Psoriasis			page) ☐ Check if used		
Stomach/duodenal ulcer			Gout					

Please list all times you have been hospitalized, operated on, or seriously injured.

Year	Operation, Illness, Injury	Hospital and City

RECENT DIAGNOSTIC TESTS

When was your last Chest X-Ray_____Date Results_____

When did you last have any Lab Tests_____Date Type_____ _____ _____

Results_____ _____ _____

YOUR FAMILY'S HEALTH HISTORY

Please give the following information about your immediate family.

Relationship	Age If Living	Age at Death	State of Health Or Cause of Dearth
Father……			
Mother……..			
Brothers			
and {…….}			
Sisters			
Spouse……..			
Children……. {			

Have any blood relatives had any of the following illnesses?
If so, indicate relationship (mother, brother, etc.)

Illness	Family Members
High Blood Pressure……	
Heart Disease…….	
Stroke…….	
Cancer……	

Diabetes…….. _____

Asthma/Emphysema/

Bronchitis…… _____

Tuberculosis…… _____

Cystic Fibrosis…… _____

Blood disease…….. _____

Glaucoma…… _____

Epilepsy…….. _____

Rheumatoid Arthritis…….. _____

Gout…… _____

Peptic Ulcer…… _____

Gallbladder disease…… _____

Colitis/Irritable Bowel…… _____

Gynecological/Obstetrical

Problems……. _____

Breast Problems…….. _____

Birth Defects……... _____

Genetic Abnormalities…… _____

Migraine Headaches……... _____

Mental Problems……. _____

Depression…….. _____

Suicide…… _____

Alcoholism……. _____

Multiple Sclerosis…….. _____

AIDS…… _____