

# Patient Health History



DIRECTION OF FEED

## Marking Instructions

- Use only a number 2 pencil.
- Fill in the complete oval as shown below.

Correct Mark  Incorrect Marks

### 1. Are you allergic to any of the following?

	Yes		Yes
Adhesive tape	<input type="radio"/>	Metal	<input type="radio"/>
Iodine	<input type="radio"/>	Seafood	<input type="radio"/>
Latex	<input type="radio"/>	Contrast Dye	<input type="radio"/>

### 2. Mark if you have been diagnosed with any of the following:

	Yes		Yes
Breast Cancer	<input type="radio"/>	Gastrointestinal	<input type="radio"/>
Lung Cancer	<input type="radio"/>	Reflux	<input type="radio"/>
Skin Cancer	<input type="radio"/>	Hepatitis	<input type="radio"/>
Throat Cancer	<input type="radio"/>	Stomach Ulcer	<input type="radio"/>
Prostate Cancer	<input type="radio"/>	Are you pregnant?	<input type="radio"/>
Other Cancer	<input type="radio"/>	Prostate Enlargement	<input type="radio"/>
Migraine Headache	<input type="radio"/>	Renal Failure	<input type="radio"/>
Cataracts	<input type="radio"/>	Stroke	<input type="radio"/>
Glaucoma	<input type="radio"/>	Anxiety	<input type="radio"/>
Nasal Allergies	<input type="radio"/>	Depression	<input type="radio"/>
Sleep Apnea	<input type="radio"/>	Diabetes	<input type="radio"/>
Blood Clots/DVT	<input type="radio"/>	Thyroid Dysfunction	<input type="radio"/>
High/Elevated Cholesterol	<input type="radio"/>	Anemia	<input type="radio"/>
Heart Attack	<input type="radio"/>	Hemophilia	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	HIV	<input type="radio"/>
Asthma	<input type="radio"/>		
Chronic Bronchitis	<input type="radio"/>		
Emphysema	<input type="radio"/>		
Tuberculosis	<input type="radio"/>		

### 3. Mark family members who have been diagnosed with any of the following:

	None	Mother	Father	Brother	Sister
Problems with Anesthesia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thyroid Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lung Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unspecified Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hearing Loss before age 20	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hearing Loss after age 20	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bleeding/Clotting Problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Name: \_\_\_\_\_

Date of Appt: \_\_\_\_\_

4. Mark if retired. Yes

5. Tobacco Use:  
Mark your tobacco use.  
 None  Cigarettes  
 Smokeless Tobacco  Cigars

Give the closest amount of cigarettes you smoke in an average day.  
 1/2 pack  2 packs  
 1 pack  3 packs  
 1 1/2 packs

Alcoholic Beverages - A drink is 1 shot of liquor or 1 glass of wine or 1 bottle/can of beer.  
 Less than 12 drinks/yr  
 1-13 drinks/mo  
 4-14 drinks/wk  
 >2 drinks/day

6. Do you use drugs recreationally? Yes

7. Caffeine Use (coffee, tea, chocolate, cola, other caffeinated drinks):  
 None  2-3 per day  
 1 per day  4 or more

8. Are you exposed to second hand smoke? Yes No

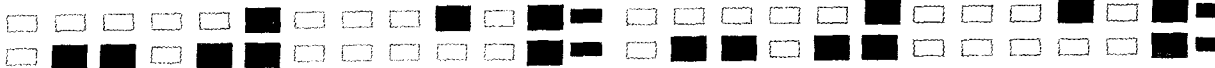
9. Mark if patient attends daycare. Yes

10. Will you accept transfusion of blood products if necessary? Yes No

11. Home Living Situation (mark all that apply).  
 Alone  With spouse  
 With children  In nursing home  
 With mother  With father  
 In assisted living  Other

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12. Do you now have or have you recently had any of the following?

	Yes	No
Fever	<input type="radio"/>	<input type="radio"/>
Sleeping problems	<input type="radio"/>	<input type="radio"/>
Unintentional weight loss	<input type="radio"/>	<input type="radio"/>
Unintentional weight gain	<input type="radio"/>	<input type="radio"/>
Blurred vision	<input type="radio"/>	<input type="radio"/>
Itchy eyes	<input type="radio"/>	<input type="radio"/>
Loss of vision	<input type="radio"/>	<input type="radio"/>
Painful eye	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>
Ear drainage	<input type="radio"/>	<input type="radio"/>
Hearing loss	<input type="radio"/>	<input type="radio"/>
Ear pain	<input type="radio"/>	<input type="radio"/>
ringing in the ears	<input type="radio"/>	<input type="radio"/>
Nasal congestion	<input type="radio"/>	<input type="radio"/>
Frequent nosebleeds	<input type="radio"/>	<input type="radio"/>
Post-nasal drainage	<input type="radio"/>	<input type="radio"/>
Belching sour material into throat	<input type="radio"/>	<input type="radio"/>
Hoarseness or other voice changes	<input type="radio"/>	<input type="radio"/>
Mouth ulcers	<input type="radio"/>	<input type="radio"/>
Partials or dentures	<input type="radio"/>	<input type="radio"/>
Blacking out or fainting	<input type="radio"/>	<input type="radio"/>
Chest pain	<input type="radio"/>	<input type="radio"/>
Heart murmur	<input type="radio"/>	<input type="radio"/>
Irregular heartbeats	<input type="radio"/>	<input type="radio"/>
Leg cramps	<input type="radio"/>	<input type="radio"/>
Swelling of ankles	<input type="radio"/>	<input type="radio"/>
Frequent non-productive cough	<input type="radio"/>	<input type="radio"/>
Frequent productive cough	<input type="radio"/>	<input type="radio"/>
Shortness of breath	<input type="radio"/>	<input type="radio"/>
Snoring (excessive)	<input type="radio"/>	<input type="radio"/>
Wheezing	<input type="radio"/>	<input type="radio"/>
Abdominal pain	<input type="radio"/>	<input type="radio"/>
Diarrhea	<input type="radio"/>	<input type="radio"/>
Heartburn	<input type="radio"/>	<input type="radio"/>
Nausea	<input type="radio"/>	<input type="radio"/>
Trouble swallowing	<input type="radio"/>	<input type="radio"/>
Painful swallowing	<input type="radio"/>	<input type="radio"/>
Vomiting	<input type="radio"/>	<input type="radio"/>
Painful joints	<input type="radio"/>	<input type="radio"/>
Stiffness in joints	<input type="radio"/>	<input type="radio"/>
Swelling of joints	<input type="radio"/>	<input type="radio"/>

12. Do you now have or have you recently had any of the following? (continued)

	Yes	No
Change in sense of smell	<input type="radio"/>	<input type="radio"/>
Change in sense of taste	<input type="radio"/>	<input type="radio"/>
Headache	<input type="radio"/>	<input type="radio"/>
Severe face pain	<input type="radio"/>	<input type="radio"/>
Seizures	<input type="radio"/>	<input type="radio"/>
Tremor	<input type="radio"/>	<input type="radio"/>
Appetite is increased	<input type="radio"/>	<input type="radio"/>
Fatigue	<input type="radio"/>	<input type="radio"/>
Cold feeling	<input type="radio"/>	<input type="radio"/>
Bleed excessively after injury	<input type="radio"/>	<input type="radio"/>
Bruise easily	<input type="radio"/>	<input type="radio"/>
Masses (lumps) in armpit	<input type="radio"/>	<input type="radio"/>
Masses (lumps) in neck	<input type="radio"/>	<input type="radio"/>
Masses (lumps) in groin	<input type="radio"/>	<input type="radio"/>
Hives	<input type="radio"/>	<input type="radio"/>
Sneezing	<input type="radio"/>	<input type="radio"/>

Thank you  
for  
completing  
this  
questionnaire!