Patient Health History

2 - 2 8 4 3 5 3

DIRECTION OF FEED

Marking Instructions

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

Correct Mark ● **Incorrect Marks** ⊘ ✓ ✗

Name: _____

Date of Appt: _____

1. Are you allergic to any of the following?

	Yes		Yes
Adhesive tape	○	Metal	○
Iodine	○	Seafood	○
Latex	○	Contrast Dye	○

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

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

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

	None	Mother	Father	Brother	Sister
Problems with Anesthesia	○	○	○	○	○
Thyroid Cancer	○	○	○	○	○
Lung Cancer	○	○	○	○	○
Unspecified Cancer	○	○	○	○	○
Hearing Loss before age 20	○	○	○	○	○
Hearing Loss after age 20	○	○	○	○	○
Heart Disease	○	○	○	○	○
High Blood Pressure	○	○	○	○	○
Asthma	○	○	○	○	○
Stroke	○	○	○	○	○
Diabetes	○	○	○	○	○
Bleeding/Clotting Problem	○	○	○	○	○

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	○	○
Sleeping problems	○	○
Unintentional weight loss	○	○
Unintentional weight gain	○	○
Blurred vision	○	○
Itchy eyes	○	○
Loss of vision	○	○
Painful eye	○	○
Dizziness	○	○
Ear drainage	○	○
Hearing loss	○	○
Ear pain	○	○
Ringing in the ears	○	○
Nasal congestion	○	○
Frequent nosebleeds	○	○
Post-nasal drainage	○	○
Belching sour material into throat	○	○
Hoarseness or other voice changes	○	○
Mouth ulcers	○	○
Partials or dentures	○	○
Blacking out or fainting	○	○
Chest pain	○	○
Heart murmur	○	○
Irregular heartbeats	○	○
Leg cramps	○	○
Swelling of ankles	○	○
Frequent non-productive cough	○	○
Frequent productive cough	○	○
Shortness of breath	○	○
Snoring (excessive)	○	○
Wheezing	○	○
Abdominal pain	○	○
Diarrhea	○	○
Heartburn	○	○
Nausea	○	○
Trouble swallowing	○	○
Painful swallowing	○	○
Vomiting	○	○
Painful joints	○	○
Stiffness in joints	○	○
Swelling of joints	○	○

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

	Yes	No
Change in sense of smell	○	○
Change in sense of taste	○	○
Headache	○	○
Severe face pain	○	○
Seizures	○	○
Tremor	○	○
Appetite is increased	○	○
Fatigue	○	○
Cold feeling	○	○
Bleed excessively after injury	○	○
Bruise easily	○	○
Masses (lumps) in armpit	○	○
Masses (lumps) in neck	○	○
Masses (lumps) in groin	○	○
Hives	○	○
Sneezing	○	○

Thank you

for

completing

this

questionnaire!