

HEALTH HISTORY QUESTIONNAIRE

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Name: _____

DOB: _____

Chronic Health Problems: (Circle all that you are currently followed for)

High Blood Pressure	High Cholesterol	Stroke	Heart Attack
Heart Failure	Irregular Heartbeat	Emphysema/COPD	Asthma
Diabetes	Reflux/Heartburn	Stomach ulcers	Headaches
Anemia	Painful Menses	Menopause	Seizures
Osteoporosis	Sinusitis	Allergies	Arthritis
Depression	Anxiety	Enlarged Prostate	Erectile Dysfunction
Glaucoma	Cancer (What kind? _____)		
Other _____			

Medications and Doses: (Please list all including vitamins and herbal therapies)

Drug Allergies

Reaction Experienced

Approximate Date

Family Health History: (Please list significant health problems of family)

Father: ___ High Blood Pressure ___ Heart Disease ___ Diabetes ___ Stroke ___ Cancer (type _____) Other _____

Mother: ___ High Blood Pressure ___ Heart Disease ___ Diabetes ___ Stroke ___ Cancer (type _____) Other _____

Brother(s): ___ High Blood Pressure ___ Heart Disease ___ Diabetes ___ Stroke ___ Cancer (type _____) Other _____

Sister(s): ___ High Blood Pressure ___ Heart Disease ___ Diabetes ___ Stroke ___ Cancer (Type _____) Other _____

Grandparents: _____

Other: _____

Social History: Do you smoke? ___ Yes ___ No If so, how much? ___ pack per day

Do you drink alcohol? ___ Yes ___ No If so, how much? ___ seldom ___ drinks per week ___ drinks per day

Have you ever used drugs (ie. cocaine, marijuana, etc.) ___ Yes ___ No

Occupation: ___ Employed ___ Retired ___ Unemployed ___ Full time Student

Education (give highest grade or degree completed): _____

Profession: _____

Religious Preference: _____

Hobbies: _____

Surgeries

Date

Reason

Hospitalizations: (Other than surgeries listed)

Date

Reason

Immunizations: Last Tetanus _____ Last Flu Shot _____ Pneumonia Vaccine _____

Health Concerns: Do you or have you had persistent problems with the following? (Please circle)

Abdominal Pain	Nausea/Vomiting	Diarrhea	Constipation
Hemorrhoids	Blood in stool	Heartburn	Gas/Bloating
Chest Pain	Palpitations	Cough	Shortness of Breath
Sinus problems	Allergies	Fever	Hoarseness
Hot flashes	Urine Infections	Urinary Urgency	Urinary Frequency
Dizziness	Fainting	Headaches	Memory Loss
Hearing Loss	Ringling in ears	Fatigue	Rash
Seizures	Anemia	Bruising	Depression
Irritability	Anxiety	Insomnia	Hair or Nail Problems
Blurred Vision	Swollen Glands	Joint Pain/Swelling	Numbness/Tingling
Back Trouble	Swelling of Ankles	Problems with Sex	History of STD's

Men:

___ Sexual dysfunction ___ Discharge from penis ___ Pain in scrotum ___ Prostate problems ___ Dribbling after voiding
___ Difficulty starting stream ___ Frequent nighttime urination Last Colonoscopy? _____

Women:

___ Age when periods began _____ Number of pregnancies _____ Number of miscarriages
Last menstrual period? _____ Are they regular? ___ Yes ___ No _____ Last Pap Smear
Severe Cramping? ___ Yes ___ No Heavy Flow? ___ Yes ___ No
Last mammogram? _____ Last bone density scan? _____
Last colonoscopy? _____