# Health History Questionnaire

***Please complete <u>both sides</u>***

name label

## Medical History

***Check only the areas that apply to you:***

- □ Atrial Fibrillation
- □ Congestive Heart Failure
- □ Heart Attack (MI)
- □ High Blood Pressure
- □ High Cholesterol
- □ Thyroid Disease □ High □ Low
- □ Peripheral Vascular Disease
- □ Diabetes Insulin? □ Yes □ No
- □ Gastric Reflux
- □ Hepatitis: □ B □ C □ other
- □ Stomach Ulcers
- □ Blood Clots
- □ HIV
- □ Sexually Transmitted Diseases
- □ Migraines
- □ Stroke
- □ TIA
- □ Dialysis
- □ Kidney Failure
- □ History of MRSA Infection
- □ History of C-Diff
- □ History of VRE
- □ Cancer (site):_____
- □ Asthma
- □ COPD (emphysema)
- □ Sleep Apnea- □ Use CPAP
- □ History of TB
- □ Chronic Pain (where)_____
- □ Rheumatoid Arthritis or Arthritis

## Eye History (indicate which eye)

***Check only the areas that apply to you:***

- □ Diabetic Eye Disease □ Right □ Left
- □ Glaucoma □ Right □ Left
- □ Macular Degeneration □ Right □ Left
- □ Cataracts □ Right □ Left
- □ Cataract Surgery □ Right □ Left
- □ Laser Surgery: Type:_____ □ Right □ Left
- □ Eye Injury □ Right □ Left
- □ Crossed or Lazy Eye □ Right □ Left
- □ Retinal Detachment □ Right □ Left
- □ Loss of Eye □ Right □ Left
- □ LASIK or RK surgery □ Right □ Left

## Family History (which family member)

***Check only the areas that apply***:

- □ Heart Disease _____
- □ Cancer _____
- □ Stroke _____
- □ Diabetes _____
- □ Hypertension _____
- □ Macular Degeneration _____
- □ Glaucoma _____
- □ Retinal Detachment _____
- □ Blindness _____
- □ Bleeding or Clotting issues _____
- □ Tumors of the Eye _____

Other:_____

## Surgeries

***Check only the areas that apply to you:***

- □ Eye Surgery_____
- □ Appendix
- □ Joint Replacement _____
- □ Gall Bladder
- □ Aneurysm Repair
- □ Angioplasty
- □ Cardiac Stent
- □ Coronary Bypass
- □ Heart Valve Replacement
- □ Hysterectomy
- □ Tubal Ligation
- □ Mastectomy: □ Right □ Left
- □ Prostate Surgery
- □ Pacemaker
- □ ICD (defibrillator)

**Height:**_____

**Weight:**_____

<u>Other Surgeries</u>

_____ _____ _____

_____ _____ _____

_____ _____ _____

## Medications

***Please list or bring list with you****

**Med: Strength: Times per day:**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

□ See Attached List

## Allergies to Medications

□ None

*Medication* *Reaction*

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

**Do you have a Latex Allergy?** □ yes □ no

## Social History

***Check only the areas that apply to you:***

- □ Drink Alcohol?
- □ Drink Caffeinated Beverages?
- □ Medical Marijuana Use?
- □ Smoke? Packs per day?_____
  Quit?___When?_____
- □ Recreational Drugs?
  Last Use?_____
- □ Do you live alone?
- □ Are you afraid of a partner/anyone?
- □ Traveled outside of the U.S. in the last month?

***Please Turn Over***
***And Fill In Back Section***

**Review of Systems**-Have you had any of these symptoms in the **PAST 30 DAYS** Please check all that apply.

name label

***Check only the areas that apply to you:***

***Constitutional:***
□ Fever
□ Weight Loss
□ Fatigue

***Eyes:***
□ Recent changes in vision
□ Eye Pain
□ Decrease in Vision

***Ears, Nose, Throat:***
□ Dry Mouth
□ Sore Throat
□ Hearing Loss
□ Hearing Aids □ Right □ Left

***Heart/Cardiovascular:***
□ Chest Pain
□ Blood Pressure under control
□ Irregular Heart Beats

***Lungs/Respiratory:***
□ Difficulty Breathing
□ Cough - Is it Productive? Y/N
□ Coughing Blood?

***Gastrointestinal:***
□ Nausea
□ Jaundice or Yellow Skin
□ Abdominal Pain

***Genitourinary:***
□ Blood in Urine
□ Pain/Burning Urination
□ Kidney Problems

***For Females****:*
□ Are or Could You Be Pregnant?
Last Menstrual Period_____
□ Are you Postmenopausal?

***Musculoskeletal:***
□ Joint Pain
□ Muscle Aches
□ Difficulty lying flat

***Integumentary/Skin:***
□ Rash
□ Skin Sores
□ Skin Cancer

***Neurologic:***
□ Dizziness
□ Weakness/Numbness
□ Seizures

***Mental Status/Psychiatric:***
□ Anxiety
□ Depression
□ Change in sleep pattern
□ Bipolar

***Endocrine:***
□ Blood Sugar Under Control
□ Heat/Cold Intolerance
□ Excessive Thirst

***Blood/Lymph:***
□ Easy Bruising/Bleeding
□ Prolonged Bleeding
□ Swollen Glands

***Allergic/Immunologic:***
□ HIV/AIDS
□ Lupus/Sjogrens
□ Seasonal Allergies

***(If applicable) Please answer these additional questions:***

Please Rate Your Pain (circle): no pain 1 2 3 4 5 6 7 8 9 10 severe pain

Have You Experienced Nausea or Vomiting After Surgery In The Past? □ Yes □ No

**Pharmacy(s):**_____

**Location of Pharmacy:**_____

**Patient Phone Number(s):**_____

**Emergency Contact:**_____ **Phone:**_____

**Patient Signature:**_____**Date:**_____

Initial:____ Date:_____ Initial:____ Date:_____ Initial:____ Date:_____

**Reviewed by:**
Initial Date
_____
_____
_____
_____
_____
_____
_____