

HEALTH HISTORY QUESTIONNAIRE

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PERSONAL HEALTH HISTORY Please check any of the following which apply to your personal history.

- | | | |
|--|--|--------------|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> High blood pressure | Other: _____ |
| <input type="checkbox"/> Heart murmur or click | <input type="checkbox"/> Bypass surgery | _____ |
| <input type="checkbox"/> Other cardiac surgery | <input type="checkbox"/> stroke | _____ |
| <input type="checkbox"/> Chest discomfort at rest | <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Chest discomfort with exertion | <input type="checkbox"/> Ankle swelling | |
| <input type="checkbox"/> Unusual shortness of breath | <input type="checkbox"/> Orthopedic problems, Arthritis | |
| <input type="checkbox"/> Chest injury | <input type="checkbox"/> Abnormal cholesterol | |
| <input type="checkbox"/> Tingling, numbness in shoulders, arms,
neck or jaw | <input type="checkbox"/> Rheumatic fever | |
| <input type="checkbox"/> Palpitations, flutter, skipped beats | <input type="checkbox"/> Rheumatic hem disease | |
| <input type="checkbox"/> Lightheadedness or fainting spells | <input type="checkbox"/> Peripheral vascular disease, blood clot | |
| <input type="checkbox"/> Frequent indigestion | <input type="checkbox"/> Stomach disorders | |
| <input type="checkbox"/> Asthma, emphysema, bronchitis | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Emotional disorders | <input type="checkbox"/> Tuberculosis | |
| | <input type="checkbox"/> Phlebitis, emboli | |

List any recent (last 5 years) illness, hospitalizations or surgical procedures: _____

List any recent accidents or injuries: _____

FAMILY HISTORY Please check any of the following conditions which apply to a blood relative (Grandparents, Father, Mother, Siblings):

	Relative	Age When Happened
Heart Attack	_____	_____
Coronary artery disease	_____	_____
Congestive heart disease	_____	_____
Stroke	_____	_____
Sudden death	_____	_____

MEDICATIONS Please list all medications, doses and when last taken:

<u>Medication</u>	<u>Dosage</u>	<u>Last Taken</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any medications: YES: _____ NO: _____ If yes, specify: _____

SMOKING HISTORY

- Never Smoked
 Cigarettes; _____ packs per day
 Cigar or Pipe
 Quit _____ years ago

ALCOHOL USAGE

- Never: _____
Monthly or less: _____
2-4 per month: _____
2-3 per week: _____
4+ per week: _____

PHYSICAL ACTIVITY

I currently exercise _____ times per week.
My exercise session lasts for _____ minutes.
My exercise consists of: _____

USE OF DRUGS

- Never
 Type _____
 Frequency _____

PATIENT'S SIGNATURE