HINDS MEDICAL GROUP
HEALTH HISTORY QUESTIONAIRE

This questionnaire will help your physician obtain a large amount of background information while still being able to focus on your most important problems. Please answer all questions as best you can. If you are uncertain about a question, your physician will help you. **All answers will be kept confidential.**

Name: _____ Today's Date: _____
Sex: _____ Age: _____ Date of Birth: _____

Medical History

Past and Current Medical Problems: (for example: measles, hepatitis, chicken pox, pneumonia, heart attack, stroke, asthma, COPD, diabetes, high blood pressure, cancer, seizures, etc.)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Operations: (for example: appendix, gallbladder, hernia, cesarean section, hysterectomy, etc.)

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

Serious Injuries: (for example: car accidents, head injuries, fractures, burns, gunshot wounds, etc.)

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

Hospitalizations: (list reason)

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

Medications: (list all medications you currently take including prescription medications, vitamins, cold medications, aspirin, birth control pills and inhalers; please list dose and how often)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies to Medications: (list all medications you cannot take or have a reactions to)

medication: _____ reaction: _____
medication: _____ reaction: _____
medication: _____ reaction: _____
medication: _____ reaction: _____

Health Habits:

Do you drink alcohol? _ No _ Yes (amount per day) _____
Do you smoke? _ No _ Yes (amount per day) _____
Did you previously smoke? _ No _ Yes (amount per day) _____ Quit When _____
Do you use caffeine? _ No _ Yes (amount per day) _____
Do you use illegal drugs? _ No _ Yes (list type) _____
Do you exercise regularly? _ No _ Yes (list type) _____

Menstrual History: (for women only)

1. Age of first menstrual period _____
2. Age of menopause _____
3. Number of pregnancies _____
4. Number of children _____
5. Number of miscarriages _____
6. Number of abortions _____

Social History:

Marital Status: (check one) _ Single _ Married _ Widower _ Separated _ Divorced
Occupation: (check one) Employed as _____ _ Student _ Retired
Highest level of education: _____
Hobbies: _____

Family History: **list any medical problems**

Father:	_ Living	_ Dead	age_____	_____
Mother:	_ Living	_ Dead	age_____	_____
Brothers:	_ Living	_ Dead	age_____	_____
	_ Living	_ Dead	age_____	_____
	_ Living	_ Dead	age_____	_____
Sisters:	_ Living	_ Dead	age_____	_____
	_ Living	_ Dead	age_____	_____
	_ Living	_ Dead	age_____	_____
Sons:	_ Living	_ Dead	age_____	_____
	_ Living	_ Dead	age_____	_____
	_ Living	_ Dead	age_____	_____
Daughters:	_ Living	_ Dead	age_____	_____
	_ Living	_ Dead	age_____	_____
	_ Living	_ Dead	age_____	_____

Please list any medical problems which run in your family:

_____

_____

_____

Travel History:

Have you ever traveled outside of the United States? _____

If yes, list countries_____

Prior Diagnostic Studies:	**No**	**Yes**	**Date**
PAP Smear	O	O	_____
Mammogram	O	O	_____
Prostate Biopsy	O	O	_____
Colonoscopy	O	O	_____
Esophageal Endoscopy	O	O	_____
EKG	O	O	_____
Cardiac Stress Test	O	O	_____
Echocardiogram	O	O	_____
Chest X-ray	O	O	_____
CT Chest	O	O	_____
Pulmonary Function Test	O	O	_____
Bone Density Test	O	O	_____

Review of Systems: Have you **RECENTLY** had any of the following problems

Constitutional	**Yes**	**No**
Fever	O	O
Night Sweats	O	O
Loss of appetite	O	O
Weight loss	O	O
Weight gain	O	O
Eyes		
Blurred vision	O	O
Double vision	O	O
Ear, Nose and Throat		
Sinus Congestion	O	O
Nose Bleeds	O	O
Sinus pain	O	O
Sore Throat	O	O
Post nasal drip	O	O
Respiratory		
Shortness of breath	O	O
Wheezing	O	O
Cough	O	O
Coughing blood	O	O
Chest pain on breathing	O	O
Sleep		
Insomnia	O	O
Daytime sleepiness	O	O
Snoring	O	O
Sudden arousals	O	O
Stop breathing at night	O	O
Wake up with headaches	O	O
Cardiovascular		
Ankle swelling	O	O
Shortness of breath	O	O
Palpitations	O	O
Leg pain on walking	O	O
Gastrointestinal		
Difficulty swallowing	O	O
Heartburn	O	O
Acid taste in mouth	O	O

Genitourinary	**Yes**	**No**
Blood in urine	O	O
Frequant urination	O	O
Diffucult urination	O	O
Painful urination	O	O
Musculoskeletal		
Arthritis	O	O
Muscle weakness	O	O
Muscle/bone pain	O	O
Skin		
Rash	O	O
Acne	O	O
Lesions	O	O
Neurological		
Seizures	O	O
Loss of consciousness	O	O
Chronic headaches	O	O
Paralysis	O	O
Hematological		
Anemia	O	O
Swollen glands	O	O
Endocrine		
Diabetes	O	O
Thyroid disease	O	O
Immunologic		
Allergies to house dust	O	O
Allergies to pollens	O	O
Allergies to animals	O	O
Risk for HIV infection	O	O

Reviewed By _____

Date _____