# HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record. PLEASE COMPLETE BOTH SIDES.

| **Name** *(Last, First, M.I.):* | ☐ Male<br>☐ Female | **Age:**<br>**Date of birth:** |
|---|---|---|

**ALLERGIES: Do you have any allergies?** ☐ **None known**

☐ **Penicillin** ☐ **Sulfa** ☐ **Iodine** ☐ **Adhesive tape** ☐ **Latex** ☐ **Seasonal** ☐ **Shellfish**
☐ **Other:**

**Please list the reaction you get:**

**Have you (or any family members) had problems with anesthesia in the past?** ☐ **Yes** ☐ **No**

**MEDICATIONS: List your medication, including vitamins & supplements. Include dose and frequency.** ☐ **None**

☐ **See List**

**MEDICAL HISTORY – Have you previously been diagnosed with (or treated for) any of the following conditions:**

| | | |
|---|---|---|
| ☐ *No current/previous health issues* | ☐ Stroke | ☐ Tuberculosis |
| ☐ High blood pressure | ☐ Thyroid disease | ☐ HIV/AIDS |
| ☐ Diabetes | ☐ Hepatitis | ☐ Osteoporosis |
| ☐ High cholesterol | ☐ Kidney disease | ☐ Mental health/psychiatric issues |
| ☐ Heart disease | ☐ Kidney stones | ☐ DVT/PE (blood clot in legs or lungs) |
| ☐ Other: | | ☐ Cancer |

**If you have/had <u>cancer</u>, what type?**

| | | | | | |
|---|---|---|---|---|---|
| ☐ Breast | ☐ Brain | ☐ Prostate | ☐ Skin | ☐ Gastric | ☐ Other: |
| ☐ Colon | ☐ Liver | ☐ Uterine | ☐ Melanoma | ☐ Lymphoma/Leukemia | |
| ☐ Lung | ☐ Kidney | ☐ Cervical | ☐ Pancreatic | ☐ Unknown | |

**PROCEDURES: Have you had any <u>procedures</u> in the past?** ☐ *None*

☐ Colonoscopy ☐ Upper endoscopy ☐ Pacemaker ☐ Angioplasty or Cardiac/coronary stents ☐ Biopsies
☐ Other:

**SURGERIES:** Have you had any <u>surgeries</u> in the past? ☐ ***No prior surgery***

| | | | |
|---|---|---|---|
| ☐ Appendectomy<br>☐ Cholecystectomy | ☐ C-section<br>☐ Hysterectomy<br>☐ Tubal ligation | ☐ Heart surgery<br>☐ Orthopedic surgery<br>☐ Tonsillectomy | ☐ Breast surgery_____<br>☐ Groin hernia repair_____<br>☐ Other hernia repair_____ |

☐ Other (please list):

**HOSPITALIZATION: Have you been hospitalized recently?** ☐ ***No recent hospitalizations.***

☐ Yes If yes, please explain:

**FAMILY HEALTH HISTORY: Do you have blood relatives with a history of illness?** ☐ *None*

☐ Diabetes ☐ Heart problems ☐ High blood pressure ☐ Stroke ☐ Bleeding tendencies ☐ Problems with anesthesia
**<u>Cancer</u>**: ☐ Breast cancer ☐ Breast with BRCA gene ☐ Colon ☐ Other Cancer:
☐ Other illness:

- CONTINUE on BACK -

| HEALTH HABITS AND HOME SITUATION | | |
|---|---|---|
| **Alcohol** | ☐ Yes ☐ No How many drinks containing alcohol in a week, on average? _____ | |
| **Tobacco** | Do you smoke? ☐ No, never ☐ Yes, I currently smoke. ☐ Yes, but I quit. What year?_____ | |
| | If yes, how many packs a day? _____ For how many years? _____ | |
| | Do you vape? ☐ Yes ☐ No | Do you use chewing (smokeless) tobacco? ☐ Yes ☐ No |
| **Drugs** | Do you smoke marijuana? ☐ Yes ☐ No | |
| | Have you used drugs, other than for medical reasons? ☐ Yes ☐ No Are you still using? ☐ Yes ☐ No<br>☐ Heroin ☐ Cocaine ☐ Methamphetamine ☐ Prescription opiates ☐ Other: _____ | |
| **Marital status:** | ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | |
| **Occupation** | Are you working? ☐ No ☐ Part-time ☐ Full-time ☐ Retired ☐ In school<br>What was/is/will be your occupation? _____ Does it involve heavy lifting? ☐ Yes ☐ No | |
| **Lives with:** | ☐ By myself ☐ Spouse/significant other ☐ Kids ☐ Other: _____ | |
| **Level of education:** | ☐ Not finished high school yet ☐ Finished high school ☐ Not finished college ☐ Finished college<br>☐ Professional schools/Masters/PhD | |

**REVIEW OF SYMPTOMS:** Please check any current symptoms you are having.

**General/Constitutional:** Have you had any changes in your general health lately?
☐ No ☐ Weight gain/loss How many lbs? _____ Over what time frame? _____
☐ Fever ☐ Chills ☐ Night sweats ☐ Fatigue/weakness ☐ Other:

**Skin:** Do you have any difficulties with your skin?
☐ No ☐ Skin disease ☐ Jaundice (yellowing of skin) ☐ Hives/eczema/rash ☐ Frequent infections/boils ☐ Abnormal pigmentation ☐ Other:

**Eyes:** Do you have any difficulties with your eyes?
☐ No ☐ Change in vision ☐ Use contacts/glasses ☐ Yellowing of eyes ☐ Other:

**Ears/Nose/Throat:** Do you have any difficulties with your ears, nose, mouth, or throat?
☐ No ☐ Nose bleeds ☐ Loss of hearing ☐ Sore throat ☐ Other:

**Neck:** Do you have any difficulties with your neck? ☐ No ☐ Neck stiffness ☐ Enlarged glands or lumps ☐ Other:

**Respiratory:** Do you have any difficulties with your breathing?
☐ No ☐ Asthma ☐ Cold symptoms (sore throat/runny nose/etc) ☐ Cough ☐ Difficulty breathing
☐ Sleep apnea ☐ Use CPAP machine ☐ Other:

**Cardiovascular:** Do you have any difficulties with your heart or circulation?
☐ No ☐ Chest pain ☐ Shortness of breath when lying down
☐ Unable to walk up two flights of stairs without chest pain or shortness of breath ☐ Swelling of hands/feet/ankles
☐ Other:

**Gastrointestinal:** Do you have any difficulties with your digestive system?
☐ No ☐ Nausea/vomiting ☐ Bleeding with bowel movements ☐ Pain with bowel movements/Recent change in bowel movements ☐ Heartburn/indigestion ☐ Abdominal pain ☐ Diarrhea ☐ Constipation ☐ Clay-colored stools
☐ Other:

**Genitourinary:** Do you have any difficulties with your urine or kidneys?
☐ No ☐ Urinary incontinence ☐ Burning/pain with urination ☐ Difficulty with urination ☐ Tea-colored urine
☐ Other:

**Musculoskeletal:** Do you have any difficulties with your muscles or bones?
☐ No ☐ Joint pain ☐ Weakness of muscles ☐ Other:

**Neurologic:** Do you have any neurologic difficulties?
☐ No ☐ Tremors ☐ Paralysis ☐ Seizures/convulsions ☐ Headaches ☐ Dizziness (sensation of room spinning)
☐ Feeling faint or passing out ☐ Other:

**Hematologic:** Do you bruise easily or have difficulty stopping bleeding?
☐ No ☐ Yes ☐ On medication that increases bleeding risk ☐ Other:

Your signature:_____ Date _____ Surgeon's signature:_____