HEALTH HISTORY QUESTIONNAIRE

PATIENT NAME:_____ DATE:_____ FILE#_____

Allergies

Onset Date	Allergy	Medication (Y/N)	Reaction Description

□Non Applicable

Family History

Relation	Living	Deceased	Age (now or at death)	Serious Illness/Cause of Death
Mother				
Father				
Sister(s)				
Brother(s)				
Daughter(s)				
Son(s)				

□Non Applicable

Hospitalizations

Date	Reason	Hospital Name

□Non Applicable

Medications

Name	Form /Strength	Quantity	Frequency	Start Date	Prescribed By?

□Non Applicable

Nutritional Supplements

Name	Manufacturer	Quantity	Frequency

□Non Applicable

Occupational History

Job Description	Work Schedule (F/T, P/T, Swing)	Activities (ex. Sitting, Standing, Walking, Computer)	Physical Stress (Low, Med., High)	Injured (Y/N)	Injury Description Ex. Fall, Crushing, Repetitive Stress, Etc.

□Non Applicable

Recreational History

Activity	Frequency Ex. Daily, Weekly, Etc.	Current Difficulty (Non-A Lot) 0-10	Pre-Injury Difficulty (Non-A Lot) 0-10

□Non Applicable

HEALTH HISTORY QUESTIONNAIRE

PATIENT NAME:_____ DATE:_____ FILE#_____

Review of Systems

Place an "X" to indicate if you have had any of the following:

□Headache	□Throat Problems	□Irritable Bowel Syndrome	□Colon Trouble	□Easy Bruising	□Diabetes Type I or II
□Sinus Problems	□Difficulty Breathing	□Liver Trouble/Hepatitis	□Diverticulitis	□Anxiety	□Hypertension
□Dizziness	□Mid Back/Rib Pain	□Kidney Problems	□Stroke	□Depression	□High Blood Pressure
□Neck Pain	□Chest Pain	□Menstrual Problems	□Knee Pain	□Unexplained Fatigue	□Cancer
□Thyroid Problems	□Wrist/Elbow/Hand Pain	□Pelvic Pain	□Ankle/Foot Pain	□Jaw Problems	□Glasses/ Contacts
□Shoulder/ Arm Problems	□Low Back Pain	□Heart Problems	□Sciatica	□Arthritis	□Frequent Infections
□Ear Problems	□Scoliosis	□Poor Circulation	□Difficulty Walking	□Chronic Cough/Cold	□Difficulty Urinating
□Asthma	□Hip/Leg Problems	□Stomach Trouble	□Skin Problems	□Osteoporosis	□Prostate Problems

If you placed an "X" above please write the onset date, and/or any other item that is not listed above please specify:_____

_____

_____

Smoking History

Years Smoked	Packs Per Day	Interest In Quitting (0-10)

□Non Applicable

Social History

Alcohol Consumption: □Multiple Times a Day □Daily □Weekly □Monthly □None □Other_____

Coffee Consumption: □Multiple Times a Day □Daily □Weekly □Monthly □None □Other_____

Soda Pop Consumption: □Multiple Times a Day □Daily □Weekly □Monthly □None □Other_____

Water Consumption Per Day: □0-2 cups □3-5 cups □6-8 cups □Other_____

Sleep Amount Per Night: □0-2 hours □2-4 hours □4-6 hours □6-8 hours □8 & above

Recreational Drug Use: □Yes □No

Healthy Eating (Bad) 0 1 2 3 4 5 6 7 8 9 10 **(Good)**

Exercise Frequency: □Daily □Multiple Times a Week □Once a Week □Multiple Times a Month

□Once a Month □Never □Other_____

Physical Stress (Non) 0 1 2 3 4 5 6 7 8 9 10 **(A lot)**

Emotional Stress (Non) 0 1 2 3 4 5 6 7 8 9 10 **(A lot)**

Notes_____