

Today's Date \_\_\_\_\_

Name \_\_\_\_\_

Place of Birth \_\_\_\_\_

**CONFIDENTIAL General History Questionnaire (Please complete both sides)**

Alcoholism	Yes/No	Diabetes	Yes/No	HIV/AIDS	Yes/No
Anxiety	Yes/No	High Thyroid	Yes/No	Eye Problems	Yes/No
Bipolar	Yes/No	Low Thyroid	Yes/No	Pneumonia	Yes/No
Depression	Yes/No	Obesity	Yes/No	Tuberculosis/TB	Yes/No
Sleep Problems	Yes/No	Eating Disorder	Yes/No	Asthma	Yes/No
Substance Abuse	Yes/No	Osteoporosis	Yes/No	Sinus Problems	Yes/No
Tobacco Use	Yes/No	Gall Bladder Disease	Yes/No	Hay Fever/Allergies	Yes/No
Stress	Yes/No	Crohn's Disease	Yes/No	Emphysema	Yes/No
Fatigue	Yes/No	Ulcerative Colitis	Yes/No	Bronchitis	Yes/No
Breast Cancer	Yes/No	Cirrhosis	Yes/No	Sleep Apnea	Yes/No
Colon Cancer	Yes/No	Colon Polyp	Yes/No	Headaches	Yes/No
Skin Cancer	Yes/No	Diverticulitis	Yes/No	Stroke	Yes/No
Leukemia	Yes/No	Heart Burn/Reflux	Yes/No	TIA/mini stroke	Yes/No
Lymphoma	Yes/No	GI Bleeding	Yes/No	Dementia	Yes/No
Lung Cancer	Yes/No	Hepatitis	Yes/No	Tremor	Yes/No
Ovarian Cancer	Yes/No	Barrett's Esophagus	Yes/No	Migraines	Yes/No
Cervical Cancer	Yes/No	Stomach/Peptic Ulcer	Yes/No	Parkinson's	Yes/No
Uterine Cancer	Yes/No	Abdominal Problems/Pain	Yes/No	Multiple Sclerosis	Yes/No
Prostate Cancer	Yes/No	Diarrhea	Yes/No	Seizure	Yes/No
Testicular Cancer	Yes/No	Constipation	Yes/No	Neck Pain	Yes/No
Other Cancer _____	Yes/No	Genital/Urinary Problems	Yes/No	Back Pain	Yes/No
Heart Disease	Yes/No	Infertility	Yes/No	Joint Pain	Yes/No
Heart Failure	Yes/No	Abnormal PAP	Yes/No	Muscle Pain	Yes/No
Atrial Fib	Yes/No	PMS/Menopause	Yes/No	Osteoarthritis	Yes/No
Blood Clots	Yes/No	Blood in Urine	Yes/No	Arthritis	Yes/No
High Cholesterol/ Triglycerides	Yes/No	Recurring Urine Infections	Yes/No	Raynaud's	Yes/No
High Blood Pressure	Yes/No	Sexually Transmitted Disease	Yes/No	Eczema	Yes/No
Heart Attack	Yes/No	Kidney Stone	Yes/No	Psoriasis	Yes/No
Heart Valve Problem/Replacement	Yes/No	Prostate Problems	Yes/No	Any other information about yourself you would like to discuss	Yes/No
		Recurring Fevers	Yes/No		

Are you **Allergic** to any medications or food? Yes/No

If Yes please list: \_\_\_\_\_

Date of last **Tetanus Shot**: \_\_\_\_\_ **Last PPD** \_\_\_\_\_ Ever Had Positive PPD? Yes/No

**Have you had any of these PROCEDURES?**

Tonsillectomy or Adenoidectomy	Yes/No	Hysterectomy: circle -partial -total	Yes/No	Upper Endoscopy	Yes/No
Angioplasty With Stent	Yes/No Yes/No	Heart By Pass (CABG)	Yes/No	ERCP	Yes/No
Appendectomy	Yes/No	Cardiac Catherization	Yes/No	Cataract	Yes/No
Tubal Ligation	Yes/No	Pacemaker	Yes/No	Hip Replacement	Yes/No
Vasectomy	Yes/No	Carpel Tunnel Release	Yes/No	Knee Replacement	Yes/No
Breast Implants	Yes/No	Colonoscopy	Yes/No	Back Surgery	Yes/No
Breast Surgery	Yes/No	Flexible Sigmoidoscopy	Yes/No	Neck Surgery	Yes/No
Removal of Ovaries	Yes/No	Cystoscopy	Yes/No	Lithotripsy	Yes/No
Caesarian Section	Yes/No	D & C	Yes/No	Organ Transplant	Yes/No
				Other _____	Please list

<b>Alcohol Use</b> Yes/No Drinks per Week: _____ _____ Glasses of Wine _____ Cans of Beer _____ Shot(s) of Liquor _____ Other drinks	<b>Tobacco Use</b> Yes/No Packs per Day : _____ Other: _____ Quit Date: _____	<b>Drug Use</b> Yes/No Types _____ Use per week _____
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<b>Sexually Active</b> Yes/No Gender of Partner(s): _____ Method of Birth Control if Used: _____ Do you practice Safe Sex? Yes/No Number of Pregnancies _____ Number of Live Births _____	<b>List your Medications/Supplements</b>
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**FAMILY HISTORY** –Please mark your family history

Relationship	Blood Pressure	Heart Disease	Diabetes	High Cholesterol	Colon Cancer	Breast Cancer	Ovarian Cancer	Lung Cancer	Prostate Cancer	Osteoporosis	COPD	Asthma	Healthy
Brother(s)													
Sister(s)													
Mother													
Father													
Maternal Grandmother													
Maternal Grandfather													
Paternal Grandmother													
Paternal Grandfather													
Son(s)													
Daughter(s)													
Uncle's													
Aunt's													

Other Family History Not Mentioned Above \_\_\_\_\_