

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

Name \_\_\_\_\_

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

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

Alcoholism	Yes/No	Asthma	Yes/No	Nose/Sinus Problems	Yes/No
Anxiety	Yes/No	Emphysema	Yes/No	Hay Fever/Allergies	Yes/No
Bipolar	Yes/No	Bronchitis	Yes/No	Skin Problems	Yes/No
Depression	Yes/No	Abdominal Problems/Pain	Yes/No	Eczema	Yes/No
Sleep Problems	Yes/No	Gall Bladder Disease	Yes/No	Psoriasis	Yes/No
Stress	Yes/No	Crohn's Disease/ Ulcerative Colitis	Yes/No	Snore or Sleep Apnea	Yes/No
Memory Problems	Yes/No	Liver Problems	Yes/No	Headaches	Yes/No
Fatigue	Yes/No	Colon Polyp	Yes/No	Stroke	Yes/No
List all Cancers you have/had _____ _____		Diverticulitis	Yes/No	TIA/mini stroke	Yes/No
		Heart Burn/Reflux	Yes/No	Dementia	Yes/No
		GI Bleeding	Yes/No	Tremor	Yes/No
Heart Disease	Yes/No	Barrett's Esophagus	Yes/No	Migraines	Yes/No
Heart Failure	Yes/No	Stomach/Peptic Ulcer	Yes/No	Parkinson's	Yes/No
Atrial Fib	Yes/No	Diarrhea	Yes/No	Multiple Sclerosis	Yes/No
Blood Clots	Yes/No	Constipation	Yes/No	Seizure	Yes/No
High Cholesterol/ Triglycerides	Yes/No	Genital/Urinary Problems	Yes/No	Neck Pain	Yes/No
High Blood Pressure	Yes/No	Infertility	Yes/No	Back Pain	Yes/No
Heart Attack	Yes/No	Abnormal PAP	Yes/No	Joint Pain	Yes/No
Heart valve problem/replacement	Yes/No	PMS	Yes/No	Muscle Pain	Yes/No
Diabetes	Yes/No	Blood in Urine	Yes/No	Osteoarthritis	Yes/No
Thyroid Problem	Yes/No	Recurring Urine Infections	Yes/No	Osteoporosis	Yes/No
Adrenal Problem	Yes/No	Sexually Transmitted Disease	Yes/No	Arthritis	Yes/No
Heat or cold intolerance	Yes/No	Kidney Stone	Yes/No	Raynaud's	Yes/No
Obesity/weight gain	Yes/No	Prostate Problems	Yes/No		
Eating Disorder	Yes/No	Recurring Fevers	Yes/No	Any other information about yourself you would like to discuss _____	
Weight Loss	Yes/No	HIV/AIDS	Yes/No		
Lung Problems	Yes/No	Eye Problems	Yes/No		
Cough	Yes/No	Ear/hearing Problems	Yes/No		
Pneumonia	Yes/No	Mouth/Oral Problems	Yes/No		
Tuberculosis/TB	Yes/No	Swollen glands	Yes/No		

NAME: \_\_\_\_\_ Date: \_\_\_\_\_

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

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

Date of last **Tetanus Shot/Immunizations:** \_\_\_\_\_ **Last PPD** and result \_\_\_\_\_

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

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 Medications:</b>
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**FAMILY HISTORY** –Please mark your family history

Relationship	Hypertension	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													

List other family history not mentioned above: \_\_\_\_\_

