WILLIS-KNIGHTON HEALTH SYSTEM

History Questionnaire

Name: ______________________ Date: ______________________

☐ Male ☐ Female Age: ________ Birth Date: ________________

Past Medical History

Name of primary care physician: ______________________ Phone Number: ________________

Address: ______________________ City: ________________ State: ________ Zip: ________

Please check (✓) all problems for which you have seen a physician or have been treated for:

	Year		Year
☐ Diabetes	_______	☐ High Cholesterol	_______
☐ Goiter	_______	☐ Migraine Headaches	_______
☐ Scarlet Fever	_______	☐ PCOS	_______
☐ COPD	_______	☐ Acid Reflux (GERD)	_______
☐ Blood Pressure	_______	☐ Endometriosis	_______
☐ Heart Attack	_______	☐ Hypothyrodism	_______
☐ Arrhythmia	_______	☐ Hyperthyroidism	_______
☐ Pain	_______	☐ Thyroid Nodules	_______
☐ Depression	_______	☐ Pituitary Adenoma	_______
☐ Arthritis	_______	☐ Osteoporosis	_______
☐ Gout	_______	☐ Cancer specify type	_______
☐ Cataracts	_______	☐ Cataracts	_______
☐ Other __________	_______	☐ Other __________	_______

Females:

Menstrual History age of onset: ________________

Date of last Mammogram: ________________

Date of last menstrual period: ________________

Number of pregancies: ________________

Number of live births: ________________

Number of miscarriages: ________________

Method of birth control: ________________

Menopause: ☐ No ☐ Yes Date: ____________

Date of last Pap: ________________

Regular: ____________ Irregular: ____________

Past Surgical History

Procedure	Year

HP0005

WILLIS-KNIGHTON HEALTH SYSTEM

Future surgeries pending: ______________________________

FAMILY HISTORY

Do any of your blood relatives have or have had any of these diseases or any other problems run in the family?

Your father: ☐ Living ☐ Deceased Age: _______ Cause of death: ____________________

Your mother: ☐ Living ☐ Deceased Age: _______ Cause of death: ____________________

Your Siblings: ______________________________

Problem/Disease	Family Member		
Diabetes		Type:	
Cancer			
Tumor/Lesion			
Heart Disease		Age of onset:	
Stroke			
TB			
Thyroid Disease		Type:	
High Blood Pressure			
Others			

SOCIAL HISTORY

Martial Status: ☐ Single ☐ Married Widowed __/__/__ Divorced __/__/__

Birthplace: ______________________________

Occupation: ☐ Retired ☐ Active ☐ Disabled ______________________________

Education: ______________________________

Employer: ______________________________

Please check No or Yes. If Yes, explain.

Do you live with others? ☐ No ☐ Yes Who? ______________________________

Do you have children? ☐ No ☐ Yes Number living: ______________________________

Do you exercise? ☐ No ☐ Yes Hours per week: _______ Type of exercise: ____________________

What is your exercise frequency? _______ times/week or __________ hours/week

Do you Smoke? ☐ No ☐ Yes Packs per day: _________ , quit ______________

Do you drink Alcohol? ☐ No ☐ Yes Type: ________ How much ______________ , quit ____________

Caffeine ☐ No ☐ Yes Type: ______________ amount daily ________________

Do you use recreational drugs? ☐ No ☐ Yes Type: ______________________________

Are you claustrophobic? ☐ No ☐ Yes

Do you feel safe in your environment? ☐ No ☐ Yes

WILLIS-KNIGHTON HEALTH SYSTEM

MEDICATIONS

Please list all current medications including, vitamins, minerals and herbals.

Medication Name	Strength	Dosage	Date Started

ALLERGIES

Do you have any drug allergies? ☐ No ☐ Yes

If yes, please check and specify allergy below:

☐ Penicillin ☐ Aspirin ☐ Codeine

Others Allergies: ____________________

Food Allergies: ____________________

History questionnaire reviewed by physician

____

Physician Signature Date/Time

____

Printed Name or Dictation #