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| --- |
| Health History Questionnaire  La Jolla Village Family Medical Group 858-450-5900  8950 Villa La Jolla Dr. Suite C129,La Jolla CA 92037 |

DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race\_\_\_\_\_\_\_\_ Ethnicity\_\_\_\_\_\_\_\_\_\_ Single\_\_\_ Divorced\_\_\_\_

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_ Married\_\_\_\_ Widower\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ All previous occupations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthplace\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ All states/countries lived in\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical examination? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all current symptoms.

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Notes

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Routine check-up-no problems\_\_\_\_\_\_

**Note: *This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Family History: If Living  Age Health | | | If Deceased  Age at  Death Cause | | Has any blood  Relative ever  Had: | Please  Circle  No or Yes | | Who |
| Father |  |  |  |  | Allergies | No | Yes |  |
| Mother |  |  |  |  | Asthma | No | Yes |  |
| Brother or Sister |  |  |  |  | Arthritis | No | Yes |  |
| 1. |  |  |  |  | Glaucoma | No | Yes |  |
| 2. |  |  |  |  | Cancer | No | Yes |  |
| 3. |  |  |  |  | Tuberculosis | No | Yes |  |
| 4. |  |  |  |  | Diabetes | No | Yes |  |
| 5. |  |  |  |  | Heart Trouble | No | Yes |  |
| 6. |  |  |  |  | High Blood Pressure | No | Yes |  |
| Husband or Wife |  |  |  |  | Stroke | No | Yes |  |
| Son or Daughter |  |  |  |  | Epilepsy | No | Yes |  |
| 1. |  |  |  |  | Substance Abuse | No | Yes |  |
| 2. |  |  |  |  | Depression | No | Yes |  |
| 3. |  |  |  |  | Emotional Problems | No | Yes |  |
| 4. |  |  |  |  | Suicide | No | Yes |  |
| 5. |  |  |  |  | Kidney Trouble | No | Yes |  |
| 6. |  |  |  |  | Thyroid Disease | No | Yes |  |

**Personal History: Circle any of the items listed below that apply to you:**

Measles (2 week)

German Measles (3 day)

Mumps

Chicken Pox

Whooping Cough

Scarlet Fever/Scarlantina

Diphtheria

Pneumonia

Influenza

Pleurisy

Rheumatic fever or any heart problem

Arthritis/Rheumatism

Any bone or joint disease

Neuritis or neuralgia

Bursitis, Sciatica, or Lumbago

Polio or Meningitis

Bladder or kidney infection

Gonorrhea, Syphilis, or Genital Herpes

Anemia

Yellow Jaundice or Hepatitis

Epilepsy

Migraine headaches

Tuberculosis

Mononucleosis

Diabetes

Cancer

High blood pressure

Low blood pressure

Nervous breakdown

Food, chemical or drug poisoning

Hay fever

Asthma

Hives

Eczema

Frequent infection of boils

Any other disease

**ALLERGIES:** Are you allergic to:

Penicillin or sulfa

Aspirin, codeine, or morphine

Mycins or other antibiotics

Merthiolate or Mercurochrome

Any other drugs

Any foods

Adhesive tape

Nail Polish or other cosmetics

**INJURIES:** Have you had any:

Broken or cracked bones

Recent Sprains

Severe lacerations

Dislocations

Concussion or head injury

Ever been knocked unconscious

Blood or Plasma transfusions

**WEIGHT:** Now\_\_\_\_\_\_ 1 year ago\_\_\_\_\_

Desired\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HABITS:**

Use of seatbelts\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcoholic beverages:

Never, 1-2 drinks/wk 3-6 drinks/wk

7-24 drinks/wk., Over 24 drinks/wk

Have been treated for alcoholism

Use: Cigarettes(\_\_\_\_) packs per day

Cigars, Pipe, Chewing Tobacco, Snuff

How long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do not smoke now but have in past

Diet\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EXERCISE:** Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency, distance or amount\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(**PLEASE TURN OVER)**

**HOSPITALIZATIONS:** List all hospitalizations (for illness or surgery), beginning with the most recent.

Date Reason Hospital M.D.

Circle any of the items below that apply to you…other than those mentioned in the above hospitalizations.

**SYSTEM REVIEW:**

Any eye disease, injury, impaired sight

Any ear disease, injury impaired hearing

Any trouble with nose, sinuses, mouth, throat

Problems with your teeth

Fainting spells

Convulsions or seizures

Paralysis or numbness

Dizziness

Frequent or severe headaches

Difficulty remembering or concentrating

Difficulty sleeping

Frequent crying spells

Difficulty related to work or family problems

Thoughts about committing suicide

Enlarged glands

Enlarged thyroid or goiter

Skin problems

Lumps in your breasts

Chronic or frequent cough

Chest pain or angina pectoris

Spiting up of blood

Night sweats

Shortness of breath

Palpitation or fluttering heart

Heart murmur

Swelling of hand, feet or ankles

Extreme tiredness or weakness

Varicose veins

Kidney disease or stones

Bladder disease

Albumin, sugar, pus, blood in urine

Difficulty urinating

Get up at night to urinate

Abnormal thirst

Stomach trouble or ulcer

Indigestion or heartburn

Liver or gallbladder disease

Colitis or other bowel disease

Hemorrhoids or rectal bleeding

Constipation or diarrhea

Recent change in appetite or eating habits

Recent change in bowel habits or stools

Black bowel movements

Stiff, painful or swollen joints

Sexual difficulties

Sex is not entirely satisfactory

Have you had a sigmoidoscopy: Yes No Date\_\_\_\_\_\_\_\_\_\_\_

**X-RAYS:** Have you had X-rays of:

Chest Stomach (Upper GI) DexaScan Date \_\_\_\_\_\_

Back Colon (Barium enema)

Extremities Gallbladder

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EKG:** Have you had an electrocardiogram: Yes No

**IMMUNIZATIONS:** Have you had these immunizations:

Measles and Mumps

Smallpox

Tetanus (date of last shot)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Polio within last 10 years

Diphtheria within last 10 years

Influenza within last year: Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumovax (Pneumonia) Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DRUGS:** Do you use:

Marijuana: Never Occasionally Regularly

Other drugs: e.g., LSD, other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Never Occasionally Regularly

**DES Exposure:** Yes No

Exposure to insecticides Yes No Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circle those used below:**

Laxatives Aspirin

Vitamins Cortisone

Tranquilizers Appetite depressants

Sleeping pills Antacids

Have you been treated for drug abuse: Yes No

Have taken insulin or tablets for diabetes: Yes No

Have taken hormone shots or tablets: Yes No

Present medications: List all prescription drugs that you are presently taking:

**Medication Dose Frequency**

**MEN ONLY**

Have you ever had swelling of or lumps on testicles? Yes No

Current method of birth control\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WOMEN ONLY**

Menstrual History: Age of onset \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last period: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

Cycle (from start to start) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_days

Usual duration of flow is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_days

Flow is: heavy medium light

Pain or cramps

Periods are irregular

Have had vaginal infections or frequent discharge Yes No

Have taken birth control pills or used an IUD Yes No

Have had abnormal PAP Yes No

Current method of birth control\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnancies: Total number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many children born alive? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many stillbirths? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many premature? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many Cesarean sections? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many miscarriages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many abortions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last mammogram \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature Date Reviewed