LAKES INTERNAL MEDICINE

HEALTH HISTORY QUESTIONNAIRE

Please print this and complete and bring to your initial appointment.

____
Today's Date

____ ________________
Last Name First Name Middle Initial Date of Birth

☐ Male ☐ Female

Education

Have you ever had any learning disabilities? ☐ Yes ☐ No Highest level of education_____________________

Medications

List below the medications you are taking. Include prescriptions and any other medicines such as aspirin, vitamins, cold medicines, "health food or herbal preparations", etc.

Name	Amount	How Often

Allergies:

Have you ever had an allergic reaction to medicine, food, or any other substance? If yes, describe below.

Substance Reaction Year

____

____

____

____

____

Immunization History:

Place a check mark next to the immunizations you have received, and indicate the year received.

Ck	Type	Year	Ck	Type	Year
	TB Test			Pneumonia	
	Tetanus			Rubella	
	Influenza, “flu shot”			Measles	
	Hepatitis B			Mumps	
	Hepatitis A			Chicken Pox	

Have you had any operations? ☐ Yes ☐ No

If yes, please describe the operation and approximate date.

Type of Operation Date

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Personal Health History:

Have you ever been treated for any of the following illnesses? If yes, place a check mark in the box next to the illness and enter the approximate date, year.

Illness		Year	Illness		Year
Migraine Headaches			Ulcer		
Head Injury			Diverticulosis		
Stroke			Colitis		
Seizures			Yellow Jaundice		
Glaucoma			Liver Trouble		
Other Eye Problems			Gallbladder Trouble		
Deafness			Hernia		
Bronchitis			Hemorrhoids		
Emphysema			Kidney Disease		
Pneumonia			Bladder Disease		
Allergies			Prostate Problems		
Asthma			Kidney Stones		
Tuberculosis			Arthritis		
Other Lung Problems			Chicken Pox		
High Blood Pressure			Diabetes		
Heart Attack			Hepatitis		
High Cholesterol			Measles		
Poor Circulation			Psoriasis		
Heart Murmur			Mental Illness		
Bleeding Tendency			Substance Abuse		
Anemia			Alcoholism		
Other Heart Condition			AIDS / HIV		
Breast Cancer			Venereal disease		
Colon Cancer			Thyroid Disease		
Prostate Cancer			Rheumatic Fever		
Other Cancer					

Have you had any serious injury? ☐ Yes ☐ No

TYPE	DATE

Family Health History

Has any member of your immediate family (mother, father, brother, sister, aunt, uncle, grandparent or child) ever been treated for any of the following illnesses? If yes, place a check mark in the box and enter the relative's relationship to you.

Illness	Check	Relationship to You
Migraine Headaches		
Stroke		
Seizures		
Glaucoma		
Deafness		
Emphysema		
Allergies		
Asthma		
High Blood Pressure		
Heart Attack		
High Cholesterol		
Bleeding Tendency		
Ulcer		
Colitis		
Kidney Disease		
Arthritis		
Diabetes		
Mental Illness		
Substance Abuse		
Thyroid Disease		
Breast Cancer		
Colon Cancer		
Prostate Cancer		
Other Cancer		

Health Maintenance:

Have you ever had a sigmoidoscopy? If so, when?_____________________________

Female Only:

Have you ever had a mammogram? If yes, date of most recent? _________________________
Do you examine your breasts monthly? ☐ Yes ☐ No

Date of last PAP smear:________________ Any abnormal PAPs?___________________

Lifestyle:

Do you live: ☐ Alone ☐ with friends ☐ with Spouse/children
☐ with spouse ☐ with significant other ☐ Relatives

# of people in household:________________

What are your hobbies/interests?____

What is (was, if retired) your occupation?____

How many hours per week do you spend at your job?______________ Retired ☐

Are you/have you been exposed to hazardous materials? If yes, what kind:__________________

How many hours of sleep per day/night do you get?_______________

Do you exercise regularly? ☐ Yes ☐ No If yes, what kind?__________________________

Do you warm-up before exercising? ☐ Yes ☐ No

If you ride a bike, do you wear a helmet? ☐ Yes ☐ No

Do you wear sunblock? ☐ Yes ☐ No

Do you wear seat-belts? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No If so, type?________________________________

Do you smoke? ☐ Yes ☐ No How much?

Do you drink alcohol? ☐ Yes ☐ No Drinks per week?

Do you drink caffeine? ☐ Yes ☐ No Drinks per day?

Do you use any non-prescription drugs? ☐ Yes ☐ No

Are there any religious issues that may affect your care? ☐ Yes ☐ No

Do you need assistance with performing daily activities? ☐ Yes ☐ No

Have you been the victim of sexual, emotional, or physical abuse / neglect? ☐ Yes ☐ No

Decision Making:

Do you have a living will? ☐ Yes ☐ No

Do you have a durable power of attorney for health care? ☐ Yes ☐ No

If you need more information about the above, ask your physician.

SYSTEM REVIEW **Patient Name**______________________________

Have you recently experienced any of the following?

CONSTITUTIONAL	Circle	
Good general heath lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes
EYES		
Eye disease or injury	No	Yes
Wear contact lenses or glasses	No	Yes
Blurred vision or double vision	No	Yes
EARS / NOSE / MOUTH / THROAT		
Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problems or rhinitis	No	Yes
Nose Bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes
Difficulty chewing or swallowing	No	Yes
Excessive Snoring	No	Yes
CARDIOVASCULAR		
Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitations	No	Yes
Shortness of breath with lying flat or walking	No	Yes
Swelling of feet, ankles or hands	No	Yes
RESPIRATORY		
Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes
GASTROINTESTINAL		
Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain or heartburn	No	Yes
Anal discharge	No	Yes
HEMATOLOGIC / LYMPHATIC		
Slow to heal after cuts	No	Yes
Phlebitis or blood clots	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

MUSCULOSKELETAL	Circle	
Joint Pain	No	Yes
Joint swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty with walking	No	Yes
GENITOURINARY		
Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change of force of stream when urinating	No	Yes
Incontinence	No	Yes
Sexual difficulty	No	Yes
Male- testicle pain	No	Yes
Male- penile discharge	No	Yes
Female- pain with periods	No	Yes
Female- irregular periods	No	Yes
Female- vaginal discharge	No	Yes
Female- # pregnancies____# miscarriages______		
Female- Date last menstrual period-___________		
Female- problems with pregnancy	No	Yes
M+F-Birth control use? Type__________________	No	Yes
INTEGUMENTARY (skin, breast)		
Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Nipple discharge	No	Yes
NEUROLOGICAL		
Frequent or recurring headaches	No	Yes
Lightheadedness or dizziness	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
PSYCHIATRIC / BEHAVIORAL		
Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes
ENDOCRINE		
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming drier	No	Yes

Physician Signature and date________________________________