Patient Health History

Marking Instructions
- Use only a number 2 pencil.
- Fill in the complete oval as shown below.

Correct Mark ▬   Incorrect Marks ◐ ✓ ✗

DIRECTION OF FEED

Name: ______________________

Date of Appt: ______________________

1. Are you allergic to any of the following?

	Yes		Yes
Adhesive tape	☐	Metal	☐
Iodine	☐	Seafood	☐
Latex	☐	Contrast Dye	☐

2. Mark if you have been diagnosed with any of the following:

	Yes		Yes
Breast Cancer	☐	Gastrointestinal Reflux	☐
Lung Cancer	☐	Hepatitis	☐
Skin Cancer	☐	Stomach Ulcer	☐
Throat Cancer	☐	Are you pregnant?	☐
Prostate Cancer	☐	Prostate Enlargement	☐
Other Cancer	☐	Renal Failure	☐
Migraine Headache	☐	Stroke	☐
Cataracts	☐	Anxiety	☐
Glaucoma	☐	Depression	☐
Nasal Allergies	☐	Diabetes	☐
Sleep Apnea	☐	Thyroid Dysfunction	☐
Blood Clots/DVT	☐	Anemia	☐
High/Elevated Cholesterol	☐	Hemophilia	☐
Heart Attack	☐	HIV	☐
High Blood Pressure	☐		
Asthma	☐		
Chronic Bronchitis	☐		
Emphysema	☐		
Tuberculosis	☐		

3. Mark family members who have been diagnosed with any of the following:

	None	Mother	Father	Brother	Sister
Problems with Anesthesia	☐	☐	☐	☐	☐
Thyroid Cancer	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐
Unspecified Cancer	☐	☐	☐	☐	☐
Hearing Loss before age 20	☐	☐	☐	☐	☐
Hearing Loss after age 20	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Bleeding/Clotting Problem	☐	☐	☐	☐	☐

4. Mark if retired. Yes ☐

5. Tobacco Use:

Mark your tobacco use.

☐ None   ☐ Cigarettes
☐ Smokeless Tobacco   ☐ Cigars

Give the closest amount of cigarettes you smoke in an average day.

☐ 1/2 pack   ☐ 2 packs
☐ 1 pack   ☐ 3 packs
☐ 1 1/2 packs

Alcoholic Beverages - *A drink is 1 shot of liquor or 1 glass of wine or 1 bottle/can of beer.*

☐ Less than 12 drinks/yr
☐ 1-13 drinks/mo
☐ 4-14 drinks/wk
☐ >2 drinks/day

6. Do you use drugs recreationally? Yes ☐

7. Caffeine Use (coffee, tea, chocolate, cola, other caffeinated drinks):

☐ None   ☐ 2-3 per day
☐ 1 per day   ☐ 4 or more

8. Are you exposed to second hand smoke? Yes ☐

9. Mark if patient attends daycare. Yes ☐

10. Will you accept transfusion of blood products if necessary? Yes ☐

11. Home Living Situation (mark all that apply).

☐ Alone   ☐ With spouse
☐ With children   ☐ In nursing home
☐ With mother   ☐ With father
☐ In assisted living   ☐ Other

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12. **Do you now have or have you recently had any of the following?**

	Yes
Fever	▢
Sleeping problems	▢
Unintentional weight loss	▢
Unintentional weight gain	▢
Blurred vision	▢
Itchy eyes	▢
Loss of vision	▢
Painful eye	▢
Dizziness	▢
Ear drainage	▢
Hearing loss	▢
Ear pain	▢
Ringing in the ears	▢
Nasal congestion	▢
Frequent nosebleeds	▢
Post-nasal drainage	▢
Belching sour material into throat	▢
Hoarseness or other voice changes	▢
Mouth ulcers	▢
Partials or dentures	▢
Blacking out or fainting	▢
Chest pain	▢
Heart murmur	▢
Irregular heartbeats	▢
Leg cramps	▢
Swelling of ankles	▢
Frequent non-productive cough	▢
Frequent productive cough	▢
Shortness of breath	▢
Snoring (excessive)	▢
Wheezing	▢
Abdominal pain	▢
Diarrhea	▢
Heartburn	▢
Nausea	▢
Trouble swallowing	▢
Painful swallowing	▢
Vomiting	▢
Painful joints	▢
Stiffness in joints	▢
Swelling of joints	▢

12. **Do you now have or have you recently had any of the following?** *(continued)*

	Yes
Change in sense of smell	▢
Change in sense of taste	▢
Headache	▢
Severe face pain	▢
Seizures	▢
Tremor	▢
Appetite is increased	▢
Fatigue	▢
Cold feeling	▢
Bleed excessively after injury	▢
Bruise easily	▢
Masses (lumps) in armpit	▢
Masses (lumps) in neck	▢
Masses (lumps) in groin	▢
Hives	▢
Sneezing	▢

Thank you for completing this questionnaire!