EDINGER MEDICAL GROUP

# GENERAL HEALTH HISTORY QUESTIONNAIRE (Initial Visit)

**NAME:** _____ **DOB:** _____ **DATE:** _____

## I. CURRENT AND PAST MEDICAL HISTORY

Please mark with an (X) any of the following illnesses and medical problems you have or have had and indicate the year when each started.
If you are not certain when an illness started, write down an approximate year.

| Illness | (X) | (Year) | Illness | (X) | (Year) |
|---|---|---|---|---|---|
| Glaucoma | ☐ | | Hemorrhoids | ☐ | |
| Deafness or Decreased Hearing | ☐ | | Kidney or Bladder Disease | ☐ | |
| Thyroid Trouble | ☐ | | Kidney Stones | ☐ | |
| Emphysema | ☐ | | Prostate Problems (male only) | ☐ | |
| Pneumonia | ☐ | | Depression | ☐ | |
| Allergies or Hay Fever | ☐ | | Headaches | ☐ | |
| Asthma | ☐ | | Head Injury | ☐ | |
| Tuberculosis | ☐ | | Stroke | ☐ | |
| Chronic Bronchitis | ☐ | | Convulsions, Seizures | ☐ | |
| Other Lung Problems | ☐ | | Arthritis | ☐ | |
| High Blood Pressure | ☐ | | Gout | ☐ | |
| Heart Attack | ☐ | | Cancer Type: _____ | ☐ | |
| High Cholesterol | ☐ | | Benign Tumor Type: _____ | ☐ | |
| Stomach / Duodenal Ulcer | ☐ | | Bleeding Tendency | ☐ | |
| Diverticulosis | ☐ | | Diabetes | ☐ | |
| Ulcerative Colitis or Crohn's Dis. | ☐ | | Life Threatening Allergic Reaction | ☐ | |
| Hepatitis / Jaundice | ☐ | | Anxiety / Panic Attack | ☐ | |
| Liver Trouble | ☐ | | Irritable Bowel Disease | ☐ | |
| Gallbladder Trouble | ☐ | | Anemia | ☐ | |
| Hernia | ☐ | | Skin Problems | ☐ | |
| Breast Lumps or Fibrocystic Dis. | ☐ | | Sexually Transmitted Disease | ☐ | |

## II. PRIOR HOSPITALIZATION AND SURGERIES

| | MONTH & YEAR | TYPE |
|---|---|---|
| OPERATIONS | | |
| | | |
| | | |
| | | |
| | MONTH & YEAR | REASON |
| HOSPITALIZATION OTHER THAN SURGERY | | |
| | | |
| | | |
| | | |

## III. CURRENT MEDICATION TAKEN

| MEDICATION | DOSE | HOW OFTEN TAKEN? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**NAME:** **DOB:** **DATE:**

## IV. ALLERGIC REACTION TO MEDICATION

| TYPE OF MEDICATION | TYPE OF REACTION |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

## V. MENSTRUAL HISTORY (WOMEN ONLY)

Date of last period _____

Number of pregnancies _____

Regular? ○ Yes / ○ No

Live Children _____

Miscarriages _____

Abortions _____

## VI. FAMILY HISTORY

If any blood relative has suffered any of the following - please indicate which relative.

| | | |
|---|---|---|
| ☐ EPILEPSY _____ | ☐ ARTHRITIS _____ | ☐ HAY FEVER _____ |
| ☐ MIGRAINES _____ | ☐ KIDNEY DIS. _____ | ☐ CANCER _____ |
| ☐ MENTAL ILL. _____ | ☐ ALCOHOLISM _____ | ☐ STROKE _____ |
| ☐ GLAUCOMA _____ | ☐ DRUG ADDICTION _____ | ☐ HYPERTENSION _____ |
| ☐ DIABETES _____ | ☐ DEPRESSION _____ | ☐ HEART DISEASE _____ |
| ☐ THYROID DIS. _____ | ☐ ASTHMA _____ | ☐ OTHER _____ |

## VII. HEALTH RISK FACTORS (Check those that apply.)

☐ Smoking: How many packs/day?_____ For how many years? _____ If you've quit, what year? _____

☐ Alcohol Consumption: Type of alcohol?_____ How much per week? _____ Per Day? _____

☐ Drug Use

☐ HIV Risk Factor (Blood Transfusions, Hemophilia, History of IV Drug Usage, High Risk Sexual Behavior)

☐ Significantly Increased Body Weight

☐ Sedentary Lifestyle

☐ Other _____

## VIII. OTHER

☐ If not currently in a mutually monogamous relationship, do you routinely use condoms? _____

☐ (Women only) Do you examine your breasts every month? _____

☐ Do you routinely wear a seatbelt? _____

☐ If you are sexually active and are not planning a pregnancy, do you use a form of contraception? _____

Which one? _____

_____
PATIENT SIGNATURE

_____, M.D.
REVIEWED

_____
PATIENT EMAIL