*R&B MEDICAL GROUP*

*Date:*

# HEALTH HISTORY QUESTIONNAIRE

**All questions contained in this questionnaire are strictly confidential and will become part of your medical record.**

| | |
|---|---|
| **Name** *(Last, First, M.I.):* ☐ M ☐ F | **DOB:** |
| **Marital status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | |
| **Previous or referring doctor:** | **Occupation:** |

## PERSONAL HEALTH HISTORY

**List any medical problems that other doctors have diagnosed**

_____

_____

_____

_____

**Surgeries**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Other hospitalizations**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |

## FAMILY HEALTH HISTORY

| | AGE | SIGNIFICANT HEALTH PROBLEMS | | AGE | SIGNIFICANT HEALTH PROBLEMS |
|---|---|---|---|---|---|
| **Father** | | | **Children** | ☐ M ☐ F | |
| **Mother** | | | | ☐ M ☐ F | |
| **Siblings** | ☐ M ☐ F | | | ☐ M ☐ F | |
| | ☐ M ☐ F | | | ☐ M ☐ F | |
| | ☐ M ☐ F | | **Grandmother** *Maternal* | | |
| | ☐ M ☐ F | | **Grandfather** *Maternal* | | |

| **MEDICATIONS** NAME OF DRUG: | STRENGTH: | FREQUENCY TAKEN: |
|---|---|---|
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| **ALLERGIES** NAME: | REACTION YOU HAD: |
|---|---|
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## HEALTH HABITS AND PERSONAL SAFETY

| **ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.** | | | | | | |
|---|---|---|---|---|---|---|
| **Exercise** | ☐ Sedentary (No exercise) | | | | | |
| | ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | | | | |
| | ☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) | | | | | |
| | ☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) | | | | | |
| **Diet** | Are you dieting? | | | | ☐ Yes | ☐ No |
| | If yes, are you on a physician prescribed medical diet?<br>Name of diet: _____ | | | | ☐ Yes | ☐ No |
| **Caffeine** | ☐ None | ☐ Coffee | ☐ Tea | ☐ Cola | | |
| | # of cups/cans per day? | | | | | |
| **Alcohol** | Do you drink alcohol regularly? | | | | ☐ Yes | ☐ No |
| | How many drinks per: Day _____ Week _____ | | | | | |
| **Tobacco** | Have you ever smoked?<br>If yes, how many per day? _____ | | | | ☐ Yes | ☐ No |
| | # of years _____ | Or year quit _____ | | | | |
| **Drugs** | Do you have any history of drug abuse?<br>If yes, briefly list which drugs _____ | | | | ☐ Yes | ☐ No |
| **Sex** | Are you sexually active? | | | | ☐ Yes | ☐ No |
| | Do you use birth control? | | | | ☐ Yes | ☐ No |
| | Do you use condoms? | | | | ☐ Yes | ☐ No |
| | Is your partner male or female? | | | | ☐ M | ☐ F |

## WOMEN ONLY

| | | |
|---|---|---|
| Are you still having monthly menstrual periods?<br>If no, when did you stop? _____ Date of last menstrual period _____ | ☐ Yes | ☐ No |
| # of pregnancies _____ # of living children _____ # of miscarriages/abortions _____ # of premature births _____ | | |
| Are you now or have you ever taken birth control?<br>If yes, please list which one _____ | ☐ Yes | ☐ No |
| Any urinary tract, bladder, or kidney infections within the last year? | ☐ Yes | ☐ No |
| Any blood in your urine? | ☐ Yes | ☐ No |
| Do you regularly have a pap test? (please check below if)<br>Date of last pap test _____ Normal _____ Abnormal _____ | ☐ Yes | ☐ No |
| Have you been sterilized?<br>If yes, please list the type of surgery _____ | ☐ Yes | ☐ No |

## MEN ONLY

| | | |
|---|---|---|
| Do you usually get up to urinate during the night? | ☐ Yes | ☐ No |
| If yes, # of times _____ | | |
| Any blood in your urine? | ☐ Yes | ☐ No |
| Has the force of your urination decreased? | ☐ Yes | ☐ No |
| Have you had any kidney or bladder infections within the last 12 months? | ☐ Yes | ☐ No |
| Do you have any problems emptying your bladder completely? | ☐ Yes | ☐ No |
| Any testicle pain or swelling? | ☐ Yes | ☐ No |
| Date of last prostate exam? _____ | | |

## PLEASE CIRCLE YES OR NO FOR THE FOLLOWING

| | | | | | |
|---|---|---|---|---|---|
| Y | N | DO YOU HAVE A CHRONIC COUGH | Y | N | HAVE YOU EVER HAD SHORTNESS OF BREATH (IF YES) |
| Y | N | DO YOU COUGH UP SPUTUM | Y | N | ONLY AFTER STRENOUS EXERCISE |
| Y | N | HAVE YOU EVER COUGHED UP BLOOD | Y | N | WHICH AWAKENS YOU AT NIGHT |
| | | | Y | N | AFTER CLIMBING A FLIGHT OF STAIRS |
| Y | N | SEVERE HEADACHES | Y | N | DO YOU HAVE PALPITATIONS |
| Y | N | NOSEBLEEDS | Y | N | HAVE YOU EVER HAD CHEST PAIN/TIGHTNESS (IF YES) |
| Y | N | BLEEDING GUMS | Y | N | WHEN EXERTING YOURSELF |
| Y | N | TROUBLE SWALLOWING/HOARSENESS | Y | N | WHEN UPSET OR EXCITED |
| | | | Y | N | RADIATES DOWN THE ARM |
| **HAVE YOU HAD:** | | | **HAVE YOU RECENTLY HAD:** | | |
| Y | N | PAIN OR BURNING IN THE STOMACH | Y | N | LEG CRAMPS OR PAIN |
| Y | N | CHANGE IN BOWEL HABBIT | Y | N | VARICOSE VEINS |
| Y | N | BLOODY OR BLACK STOOL | Y | N | PHLEBITTIS OR INFLAMED LEG VEINS |
| Y | N | DIARRHEA OR CONSTIPATION | Y | N | SWELLING IN ANKLE |
| | | | Y | N | SWELLING OR PAIN IN JOINTS |
| **HAVE YOU HAD:** | | | **ANY RECENT CHANGES IN:** | | |
| Y | N | PAIN OR BURNING ON URINATION | Y | N | WEIGHT |
| Y | N | TROUBLE HOLDING URINE | Y | N | ENERGY LEVEL |
| Y | N | KIDNEY STONES | Y | N | ABILITY TO SLEEP |
| Y | N | GETTING UP FREQUENTLY AT NIGHT TO URINATE | | | |
| **HAVE YOU HAD:** | | | **HAVE YOU OR DO YOU CURRENTLY HAVE:** | | |
| Y | N | SEIZURES | Y | N | THYROID PROBLEMS |
| Y | N | MENTAL/EMOTIONAL ILLNESS | Y | N | DIABETES |
| Y | N | ANXIETY | | | |
| Y | N | DEPRESSION | | | |

**ANY OTHERS NOT LISTED ABOVE:** _____