Dr. Ronald Bush

HEALTH HISTORY QUESTIONNAIRE

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

First Name _____ Last Name _____

Sex:

◯ Male ◯ Female

Date of Birth _____

Marital Status:

◯ Single ◯ Partenered ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

Previous Referring Dr. _____ Date of Last Exam _____

Personal History

Childhood Illness:

◯ Measles ◯ Mumps ◯ Rubella ◯ Chickenpox ◯ Polio ◯ Rheumatic Fever

Immunization and Dates:

Tetanus	☐	Date:
Pneumonia	☐	Date:
Hepatitis	☐	Date:
Chickenpox	☐	Date:
Influenza	☐	Date:
Measles	☐	Date:
Mumps	☐	Date:
Rubella	☐	Date:

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries:

Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital
Year	Reason	Hospital

Have you ever had a blood transfusion?

◯ Male ◯ Female

Date of Transfusion

Location

Woman Only

Age at onset menstruation:

Date of last menstruation

Period every _____ days.

Heavy Periods, Irregular, Spotting, Pain, Discharge?

◯ Yes ◯ No

Number or Pregnancies

Number or Live Births

Are you pregnant or breast feeding?

◯ Yes ◯ No

Have you had a D&C, Hysterectomy, or Cesarean?

◯ Yes ◯ No

Any urinary tract, bladder, or kidney infections within the last year?

◯ Yes ◯ No

Any blood in your urine?

◯ Yes ◯ No

Any hot flashes or sweating at night?

◯ Yes ◯ No

Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around the period?

◯ Yes ◯ No

Experienced any recent breast tenderness, lumps, or nipple discharge?

◯ Yes ◯ No

Date of last pap and rectal exam

Any problem with control of urination?

◯ Yes ◯ No

Men Only

Do you usually get up to urinate during the night?

◯ Yes ◯ No

Do you feel pain or burning with urination?

◯ Yes ◯ No

Do you feel pain or burning with urination?

◯ Yes ◯ No

Any blood in your urine?

◯ Yes ◯ No

Do you feel burning discharge from penis?

◯ Yes ◯ No

Has the force of your urination decreased?

◯ Yes ◯ No

Have you had any kidney, bladder, or prostate infections within the last 12 months?

◯ Yes ◯ No

Do you have any problems emptying your bladder completely?

◯ Yes ◯ No

Any difficulty with erections or ejaculation?

◯ Yes ◯ No

Any testicle pain or swelling?

◯ Yes ◯ No

_____

Date of last prostate and rectal exam

Other Problems

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain

Skin	☐	Head / Neck	☐
Ears	☐	Nose	☐
Throat	☐	Lungs	☐
Chest / Heart	☐	Back	☐
Intestinal	☐	Bladder	☐
Bowl	☐	Circulation	☐

Recent Changes in:

Weight	☐	Energy Level	☐
Ability to Sleep	☐	Other Pain / Disconfort	☐

Sexual History

Are you sexually active?

◯ Yes ◯ No

Any discomfort with intercourse?

◯ Yes ◯ No

Do you feel pain or burning with urination?

◯ Yes ◯ No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?

◯ Yes ◯ No

Do you live alone?

◯ Yes ◯ No

Do you have frequent falls?

◯ Yes ◯ No

Do you have vision or hearing loss?

◯ Yes ◯ No

Do you have an Advance Directive or Living Will?

◯ Yes ◯ No

Would you like information on the preparation of these?

◯ Yes ◯ No

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?

◯ Yes ◯ No

Family History

	Age	Significant Heart Problems
Father	_____	☐
Mother	_____	☐
Grandmother (Maternal)	_____	☐
Grandfather (Maternal)	_____	☐
Grandmother (Paternal)	_____	☐
Grandfather (Paternal)	_____	☐

	Age			Significant Heart Problems
Sibling 1	_____	◯ Male	◯ Female	☐
Sibling 2	_____	◯ Male	◯ Female	☐
Sibling 3	_____	◯ Male	◯ Female	☐
Sibling 4	_____	◯ Male	◯ Female	☐
Sibling 5	_____	◯ Male	◯ Female	☐
Children 1	_____	◯ Male	◯ Female	☐
Children 2	_____	◯ Male	◯ Female	☐
Children 3	_____	◯ Male	◯ Female	☐
Children 4	_____	◯ Male	◯ Female	☐

Mental Health

Is stress a major problem for you?

◯ Yes ◯ No

Do you feel depressed?

◯ Yes ◯ No

Is stress a major problem for you?

◯ Yes ◯ No

Do you feel depressed?

◯ Yes ◯ No

Do you cry frequently?

◯ Yes ◯ No

Have you ever attempted suicide?

◯ Yes ◯ No

Have you ever seriously thought about hurting yourself?

◯ Yes ◯ No

Do you have trouble sleeping?

◯ Yes ◯ No

Have you ever been to a counselor?

◯ Yes ◯ No

List your prescribed and over-the-counter drugs , such as vitamins and inhalers

Name the Drug	Strength	Frequency
Name the Drug	Strength	Frequency
Name the Drug	Strength	Frequency
Name the Drug	Strength	Frequency
Name the Drug	Strength	Frequency
Name the Drug	Strength	Frequency

Allergies

Drugs allergic to	Reactions
Drugs allergic to	Reactions
Drugs allergic to	Reactions
Drugs allergic to	Reactions

Health and Personal Safety

Exercise

- ☐ Sedentary (no exercise)
- ☐ Mild Exercise (l. e. , climb stairs, walk 3 blocks, golf)
- ☐ Occasional Vigorous Exercise (l. e., work or recreation, less than 4x/a week for 30 minutes)
- ☐ Regular Vigorous Exercise (l. e., work or recreation 4x/a week for 30 minutes))

Diet

Are you dieting?

◯ Yes ◯ No _____ # of meals you eat in an average day

Rank Salt Intake

◯ High ◯ Medium ◯ Low

Rank Fat Intake

◯ High ◯ Medium ◯ Low

Caffeine

◯ None ◯ Coffee ◯ Tea ◯ Cola _____ # of cups/cans per day

Alcohol

Do you drink alcohol?

◯ Yes ◯ No

Are you concerned about the amount you drink?

◯ Yes ◯ No

Have you considered stopping?

◯ Yes ◯ No

Have you ever experienced blackouts?

◯ Yes ◯ No

Are you prone to "binge" drinking?

◯ Yes ◯ No

Do you drive after drinking?

◯ Yes ◯ No

Do you use tobacco?

◯ Yes ◯ No ◯ Cigarettes ◯ Chew ◯ Pipe ◯ Cigars

Drugs

Do you currently use recreational or street drugs?

◯ Yes ◯ No

Have you ever given yourself street drugs with a needle?

◯ Yes ◯ No