JOB: health_history1.g -- p1, sep1: FCP_700
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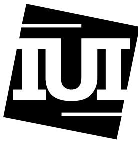

IDAHO
UROLOGIC
INSTITUTE

HEALTH HISTORY QUESTIONNAIRE

Today's Date: ______________

Name: ______________________________ Age: ____ Primary Care Physician: ______________

Reason for visit: ______________________________

When did symptoms first occur? ______________________________

Have you seen another Physician for this problem? ____ Who? ______________ When? ______________

Do you have allergies to foods or medications? Please list, including reaction.

Food or Medication	**Reaction**

Please list current medications:

Medication	**Dosage**	**Prescribing MD**

Please list all times you have been admitted to the hospital for illness or surgery.

Year	**Illness or Surgery**	**Physician**

When was your last physical exam? ______________________________

YOUR PAST HEALTH 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 the illness started, write down the approximate year.

(X)	Illness	Year
❑	Asthma	
❑	Emphysema	
❑	Chronic Disease(s)	
❑	Phlebitis	
❑	Stomach or Duodenal Ulcer	
❑	Hepatitis	
❑	Rectal Problems	
❑	Diabetes	
❑	Arthritis	
❑	Seizures	
❑	Smoke or chew tobacco	

Packs per day ______
Age started ______
Age quit ______

(X)	Illness	Year
❑	Urinary Problems	
❑	Prostate Problems	
❑	Kidney Stones	
❑	Breast Problems	
❑	Heart Problems	
❑	Heart Valves	
❑	High Blood Pressure	
❑	Angina	
❑	Thyroid Problems	
❑	Kidney Problems	
❑	Hemorrhoids	
❑	Abnormal Lumps	
❑	Cancer	

Type: ______________

❑ Drink Alcohol
How often? ______________
How much? ______________

YOUR FAMILY'S HEALTH HISTORY - Information needed on immediate family only.

Relationship	**Age, if living**	**Age at death**	**State of health or cause of death** (Example: Cancer, Diabetes, Heart Disease)
Father			
Mother			
Brother(s)			
Sister(s)			