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 ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed ☐ Significant Other		

Preferred language:	**Interpreter needed?**	☐ Yes	☐ No
Referring doctor:	**Date of planned hospitalization:**		

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Describe reason for planned hospitalization:

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No
Any objections to receiving blood products?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins, herbal medications and treatments, and inhalers		
Name the Drug	Strength	Frequency Taken

What pharmacy do you use for your prescription medications?		
Would you prefer to have discharge prescriptions printed or sent electronically to your pharmacy?	☐ Printed	☐ Sent electronically

Allergies to medications	
Name the Drug	Reaction You Had

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?			☐ Yes	☐ No
	# of meals you eat in an average day?				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	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
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ 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
Personal Safety	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 HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ 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

SYSTEMS REVIEW

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

NEUROMUSCULAR SYSTEM

☐ Previous stroke (CVA)	☐ Imbalance	☐ Recent falls
☐ Previous mini-stroke (TIA)	☐ Abnormal gait	☐ Recent need for walking aides
☐ Headaches	☐ Limited mobility	☐ Recent difficulty walking
☐ Seizures	☐ Limited movement of joints	☐ Recent difficulty talking
☐ Vertigo/Dizziness	☐ Arthritis	☐ Recent difficulty swallowing
☐ Paralysis	☐ Contractures	☐ Recent difficulty with hygiene
☐ Back problems	☐ Amputee	☐ Recent difficulty getting in/out of bed/chair

EYES, EARS, NOSE, THROAT

☐ Vision changes	☐ Nasal congestion	☐ Tinnitus/ringing ears
☐ Eye redness	☐ Nose bleeds	☐ Deaf ☐ Right ear ☐ Left ear
☐ Cataracts	☐ Nasal drainage	☐ Difficulty hearing Right ear
☐ Glaucoma	☐ Mouth ulcers	☐ Difficulty hearing Left ear
☐ Blindness ☐ Right eye ☐ Left eye	☐ Dentures	☐ Ear drainage
☐ Eye drainage	☐ Partial Plate	☐ Dizziness
☐ Eye swelling/edema	☐ Hoarse voice	☐ Fainting/syncope

RESPIRATORY SYSTEM

☐ Frequent colds	☐ Sleep apnea	☐ Difficulty breathing
☐ Asthma	☐ CPAP/BIPAP	☐ Difficulty breathing while lying down
☐ COPD	☐ Home oxygen	☐ Cough for more than 3 weeks
☐ Tracheostomy	☐ Nebulizer	☐

CARDIOVASCULAR SYSTEM

☐ Heart disease	☐ Angina	☐ Varicose veins
☐ Irregular heartbeat	☐ Edema	☐ History of blood clots
☐ Rheumatic fever	☐ Heart palpitations	☐ Leg pain
☐ Valve replacement	☐ Heart murmur	☐ Numbness
☐ Congestive heart failure	☐ Hypertension	☐

☐ Heart attack	Date?
☐ Defibrillator/pacemaker	Year implanted/type/rate?
☐ Bypass surgery	Date/where?

GASTROINTESTINAL SYSTEM

☐ Ulcers	☐ Bowel incontinence	☐ Chronic diarrhea
☐ Hemorrhoids	☐ Ostomy	☐ Chromic constipation
☐ Rectal bleeding	☐ Feeding tube	☐ Chronic pain
☐ Indigestion	☐ Gallbladder disease	☐ Elimination aides
☐ Reflux	☐	☐

NUTRITIONAL REVIEW

☐ History of cancer	☐ Bed sore/Decubitus ulcer	☐ New diagnosis of diabetes
☐ History of head injury	☐ Pregnant or lactating woman	☐ Malnutrition
☐ History of trauma	☐ Difficulty swallowing or chewing	☐ Tube feed/Parenteral nutrition
☐ Surgical patient over age 75	☐ Unintentional weight loss	☐ Dietary restrictions

GENITOURINARY SYSTEM

☐ Urinary incontinence	☐ Blood in urine	**Females**
☐ Urinary frequency	☐ Kidney disease / stones	Last menstrual period ___________
☐ Stress incontinence	☐ Sexually transmitted disease	☐ Menstrual pain / unusual bleeding
☐ Nighttime urination	☐ Ileal conduit	☐ Currently pregnant
☐ Frequent urinary infections	**Males**	# of pregnancies ___________
☐ Urinary catheter	☐ Difficulty emptying bladder	# of live births ___________
☐ Painful urination	☐ Reduced force of urine flow	☐

ENDOCRINE SYSTEM

☐ Bleeding disorder	☐ Anemia	☐ Liver disease
☐ Thyroid disorder	☐ Hepatitis	☐ Hormone treatments
☐ Diabetes	☐	☐

PAIN REVIEW

Describe any current pain / location / duration / intensity / description / what relieves pain / what causes pain to increase

Describe how pain affects any of the following

Sleep		Mood	
Activity		Nutrition	
Elimination		Social interaction	
Self image		Sexuality	

ADDITIONAL QUESTIONS TO HELP WITH YOUR HOSPTIAL STAY AND RECOVERY	
Primary caregiver / phone number	
Emergency contact / phone number	
Any recent life events the healthcare team should be aware of?	
Any cultural beliefs the healthcare team should be aware of?	
Would you like the Lourdes pastoral team and/or personal clergy notified? Please include contact information for personal clergy if you would like us to make the notification.	
Any additional information the healthcare team should be aware of that has not already been address in the questionnaire?	