



# Lake Village Clinic

## History Questionnaire

Patient's Full Name: \_\_\_\_\_

Spouse or Responsible Party: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Date of Last Physical Exam: \_\_\_\_\_ Date of Last Pap Smear: \_\_\_\_\_

### Personal History (Yes or No)

\_\_\_\_\_ Diabetes

\_\_\_\_\_ Tuberculosis

\_\_\_\_\_ Cancer

\_\_\_\_\_ Heart Disease

\_\_\_\_\_ High Blood Pressure

\_\_\_\_\_ Blood Disease

Other Diseases not mentioned \_\_\_\_\_

Operations, Injuries, and approximate dates: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Hospitalizations (X-rays & EKG's), other than for operations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Diet Restrictions: \_\_\_\_\_ Yes \_\_\_\_\_ No

Smoke: \_\_\_\_\_ Yes \_\_\_\_\_ No

Living Will: \_\_\_\_\_ Yes \_\_\_\_\_ No

Marital Status: Single, Married, Divorced, Widowed    Number of Children: \_\_\_\_\_

Immunizations: Last Tetanus \_\_\_\_\_ Influenza \_\_\_\_\_ Pneumovax \_\_\_\_\_

Work History: Toxin Exposure: \_\_\_\_\_ Yes \_\_\_\_\_ No

Retired: \_\_\_\_\_ Yes \_\_\_\_\_ No

Medical Disability: \_\_\_\_\_ Yes \_\_\_\_\_ No



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## History Questionnaire (continued)

### Family History

If Living: Age and Medical Problems

If Deceased: Age at Death and Cause of Death

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Brother (s): \_\_\_\_\_

Sister (s): \_\_\_\_\_

Is there a family history of:

	Yes	No	Relationship
Diabetes			
Cancer			
Stroke			
Hypertension			
Arthritis			
Heart Disease			
Other			

List all the medications (Prescription and Over the Counter) you are currently taking. Include dose (mgm) and how many times a day your take each one.

Medication	Dose (mgm)	How Often?

Allergies:

Drugs: \_\_\_\_\_

Food: \_\_\_\_\_

Other: \_\_\_\_\_



History Questionnaire (continued)

STUDY OF SYSTEMS																
Check Yes or No for each item except where applies to male or female																
Condition			Yes	No	Condition			Yes	No	Condition			Yes	No		
Head	Fever			Neck	Stiffness			Psychological	<b>Is Your Life:</b>							
	Chills				Swelling				Satisfactory							
	Bruise Easily				Lumps				Boring							
	Swollen Glands				Other*				Demanding							
	Loss of Memory			Gastrointestinal	Appetite Poor				Unsatisfactory			<b>Is There Worry Over:</b>				
	Genreal Weakness				Indigestion/Heartburn				<b>Home Life</b>							
	Aches/Pains				Nausea				Marriage							
	Double Vision				Vomiting Blood				Job							
	Light Flashes				Abdominal Pain or Cramps				Children							
	Blurred Vision w/o Glasses				Abdominal Tension				Money							
Halos Around Lights			Biarrhea				<b>Do You:</b>									
Eye Pains			Constipation				Often feel Depressed									
Ear Pains			Bowel Habit Changes				Have Irrational Fears									
Ear Drainage			Rectum Blood Passage				Feel Upset									
Buzzing/Ringing in Ears			Black Tar-Type Bowel Movements			Feel Things Often Go Wrong										
Nosebleeds			Other*			Feel Shy										
Sinus Problems			Kidney	Up Nights to Urinate			Cry Easily									
Swallowing Problems				Blood in Urine			Feel Inferior									
Deafness				Burning or Pain While Urinating			<b>Have You:</b>									
Mouth, Tooth or Tongue Problems				Problems Passing Urine			Attempted Suicide									
Persistent Hoarseness				Trouble Controlling Urine			Seriously Considered Suicide									
Servre Headaches				Other*			Men Genitalia	Lump In Testicle								
Other*			Neu Musc	Leg or Arm Weakness				Penis Discharge								
Rash				Balance Problems				Breast Lump								
Changing Moles				Dizziness				Sore on Penis								
Pigmentation				Fainting Spells				Erection Difficulites								
Other Skin Problems*			Speech Problems			Other*										
Chest Heart Lungs	Irregular Heartbeat			Other*	Bone Joint	Joint Pains			Women Genitalia	Breast Lump						
	Shortness of Breath					Joint Swelling				Nipple Discharge						
	Low Exercise Tolerance					Muscle Strength Loss				Vaginal Discharge						
	Heart Flutters			Muscle Lump or Swelling				Non-Period Bleeding/Spotting								
	Chest Pains			Lump on Bone				Hot Flashes								
	Frequent Coughs			Pains in Back				Pain with Intercourse								
	Cough Up of Blood			Other*				Possibly Pregnant								
	Wheezing			Endocrine		Constant Thirst				Change in Periods						
	Night Sweats					Most Always Cold				Pain Other Than with Periods						
	Swollen Ankle					Too Warm Most Times				Other*						
Cramps in Legs			Very Sluggist or Tired													
Other*			Jumpy / Nervous													
Explain Other*																
Doctor's Use Only - Summary																