Northwest Iowa P.C. Surgeons

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Sex: _____ Account Number: _____

Date of Birth: _____ Family/Referring Physician: _____

Allergies:

_____
_____
_____

Surgeries:

_____
_____
_____

Medications and Dosage (Prescription and Over-the-Counter):

_____
_____
_____
_____
_____
_____
_____

Last Colonoscopy:

_____

Last Mammogram:

_____

Last Pap Smear:

_____

Influenza Vaccination Date: _____

Pneumonia Vaccination Date: _____

HEALTH HABITS:

Date of last physical?: _____ Blood Pressure: _____

Height: _____ Weight: _____ Heaviest Weight: _____

Do you exercise?: _____ How Much?: _____ Hours/Week: _____

Do/did you smoke?: _____ How Much?: _____ Packs/Day: _____
Number of years?: _____ Year you quit: _____
Cigarettes/Chewing Tobacco/Cigars/Pipe (please circle)

Do/did you drink alcohol?: _____ How Much?: _____ Drinks/Week: _____
Number of years?: _____ Year you quit: _____

Do you have vision loss?: _____ Glasses/Contacts: _____ Other: _____

Do you have hearing loss?: _____ Hearing Aids: _____ Other: _____

FAMILY HEALTH HISTORY:

	Age	Health Problems		Sex/Age	Health Problems
Father			Children		
Mother					
Sibling					
			Grandparents (Paternal)		
			Grandparents (Maternal)		

Personal Health Problems and History (Circle if you have or have had any symptoms listed):

Sleep Disorder	Clotting Disorder	Migraines	Hepatitis
Restless Sleep	Blood Clot	Hearing Problems	Drug Addiction
Snoring	Heart Murmur	Energy Level	Alcoholism
COPD	Shortness of Breath	Bowel/Intestinal	STD's
Asthma	Throat	Skin	Urination
Cough	Ulcers	Abnormal Mammogram	Abnormal Pap Smear
Seizures	Shingles	Breast Problems	Irregular Menses
Diabetes	Depression	Hemorrhoids	Night Sweats

Describe any urinary trouble: _____

_____

Any other concerns: _____

_____

_____

FEMALE PATIENTS ONLY:

Age of first period: _____ Date of last period: _____

Number of pregnancies: _____ Birth Control Method: _____

Number of living births: _____

Patient Signature: _____ **Date:** _____