

**Overlake Arthritis and Osteoporosis Center PLLC .  
HEALTH HISTORY QUESTIONNAIRE**

**FAMILY HISTORY**

	<b>Current health</b>	<b>Age if Living</b>	<b>Major Illnesses</b>	<b>Cause of Death</b>
<b>Father</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Mother</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Grandparents</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Brothers</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Sisters</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**HABITS**

	<b>Frequency of use</b>	<b>Duration of use</b>
<b>Smoking</b>	<input type="text"/>	<input type="text"/>
<b>Alcohol</b>	<input type="text"/>	<input type="text"/>
<b>Coffee/Tea</b>	<input type="text"/>	<input type="text"/>

**CURRENT MEDICATIONS (include dosage)**

1.
2.
3.
4.
5.
6.

**ALLERGIES TO MEDICINES**

	<b>Type of Reaction</b>	<b>Date Taken</b>
1. <input type="text"/>	<input type="text"/>	<input type="text"/>
2. <input type="text"/>	<input type="text"/>	<input type="text"/>
3. <input type="text"/>	<input type="text"/>	<input type="text"/>

**CURRENT MEDICAL PROBLEMS**

**PAST HEALTH**

**Hospitalizations**

1.

2.

3.

**SYMPTOMS (List present ones first)**

**HEAD RELATED**

**Yes/No**

**Date**

**Yes/No**

**Date**

Headaches	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>	Eye Problems	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>
Dizziness	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>	sinus	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>
Ear Problems	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>	Swallowing Trouble	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>

**RESPIRATORY**

**Date**

**Date**

Cough	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>	Asthma	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>
Short Breath .....	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>	Chest Pain	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>

**HEART**

**Date**

**Date**

High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>	Rapid/irregular heart beat	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>
Short of breath at night	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>	Heart Pain	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>
Edema or Fluid Retention	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>				

**GASTROINTESTINAL**

**Date**

**Date**

Indigestion. ....	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>	Constipation	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>
Heartburn .....	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>	Diarrhea	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>
Ulcer .....	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>	Black Stool	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>
Nausea	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>	Blood in Stool	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>
Vomiting	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>	Abdominal Pain	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>
Liver Problems .....	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>	Weight Loss	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>

**MENSTRUAL**

**Date**

**Date**

Menopause .....	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>	Vaginal Infections	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>
Hysterectomy .....	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>	Pregnancy	<input type="radio"/>	<input type="radio"/>	<input style="width: 80px;" type="text"/>

Hormone Use .....

Births

**KIDNEY**

**Date** **Date**

Infection

Kidney Stones

Blood in Urine

Urination at Night

**PROSTATE**

**Date** **Date**

Infection

Tumor

**SKELETAL**

**Date** **Date**

Muscle/Joint Pain

Injuries to Joints

Swelling in Joints

Joint involved

Stiffness in Joints

**NERVOUS SYSTEM**

**Date** **Date**

Muscle Weakness

Loss of Sensation

Numbness

Loss of Balance

Loss of Coordination

**EMOTIONS**

**Date** **Date**

Tenseness

Stress Situations now

Depression

Edema or Fluid Retention

**SKIN**

**Date** **Date**

Rashes

Skin Cancers

Itching

skin Sensitivity

**METABOLIC**

**Date** **Date**

thyroid Problems

Cold Sensitivity

**CIRCULATION**

**Date** **Date**

Muscle Pain with Use???

Skin Ulcers

**OTHER INFORMATION:**

Full name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_