OVERLAKE ARTHRITIS & OSTEOPOROSIS CENTER, PLLC

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Health History Questionnaire

Name: _____ **Date:** _____

Family History: (list age, current health, major illnesses, and cause of death)

- ☐ **Mother**
- ☐ **Father**
- ☐ **Grandparents**
- ☐ **Sisters**
- ☐ **Brothers**

Habits: (list amount and duration of use)

☐ **Smoking** _____ ☐ **Alcohol** _____ ☐ **Coffee or Tea** _____

Current Medications: (list name, amount, and frequency of use)

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

Allergies to Medicines: (list medicine, type or reaction, date)

Current Problem:

Past Health:

Hospitalizations

1.
2.
3.

Symptoms: (list present ones first; those from the past, list with the date)

Head:

- ☐ **Headaches**
- ☐ **Dizziness Ear Problems**
- ☐ **Eye Problems**
- ☐ **Sinus**
- ☐ **Swallowing Trouble**

Respiratory:

- ☐ **Cough**
- ☐ **Short of Breath**
- ☐ **Asthma**
- ☐ **Chest Pain**

Heart:

- ☐ High Blood Pressure
- ☐ Short of Breath at Night
- ☐ Rapid or Irregular Heart Beat
- ☐ Heart Pain
- ☐ Edema or Fluid Retention

Gastrointestinal:

- ☐ Indigestion
- ☐ Heartburn
- ☐ Ulcer
- ☐ Nausea
- ☐ Vomiting
- ☐ Liver Problems
- ☐ Constipation
- ☐ Diarrhea Black
- ☐ Stools Blood in
- ☐ Stools
- ☐ Abdominal Pain
- ☐ Weight Loss

Menstrual:

- ☐ Menopause
- ☐ Hysterectomy
- ☐ Hormone Use
- ☐ Vaginal Infection
- ☐ Pregnancies
- ☐ Children

Kidney:

- ☐ Infection
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ Urination at night

Prostate:

- ☐ Infection
- ☐ Tumor

Skeletal:

- ☐ Muscle or Joint Pain
- ☐ Swelling in Joints
- ☐ Stiffness in Joints
- ☐ Back Pain
- ☐ Injuries to Joints
- ☐ Joints Involved

Nervous System:

- ☐ Muscle Weakness
- ☐ Numbness
- ☐ Loss of Coordination
- ☐ Loss of Sensation
- ☐ Loss of Balance

Emotions:

- ☐ Tenseness
- ☐ Depression
- ☐ Stress Situations Now

Skin:

- ☐ Rashes
- ☐ Itching
- ☐ Skin Cancers
- ☐ Sun Sensitivity

Metabolic:

- ☐ Thyroid Problems
- ☐ Cold Sensitivity

Circulation:

- ☐ Muscle Pain with Use
- ☐ Skin Ulcers

Other Information: