



HEALTH HISTORY QUESTIONNAIRE

Name: _____ DOB: _____ Sex: M F Age: _____

Vaccine: Pneumonia Influenza Covid-19 Dates Administered: _____ Primary Dr: _____

***Pneumococcal vaccine administered on or after patient's 60th birthday and before the end of the measurement period (G9991)*

Do you currently have, or have you ever had?

Eyes/Ears:

YES NO

- Contact Lens Wearer: Type** _____
- Refractive Surgery (Lasik): date** _____
- History of injury – Type _____
- Glaucoma
- Hearing Loss R L Both
- Hearing Aids? R or L / Both

Endocrine:

- Thyroid: Hyper or Hypo
- Diabetes – Insulin, pills, or diet controlled

Cardiovascular:

- High Blood Pressure
- Peripheral vascular disease
- Atrial Fibrillation/Palpitations
- Heart Attack: date _____
- Murmur /history of Rheumatic fever
- Chest pain/Angina – how often _____
If yes, how treated _____
- High Cholesterol
- Pacemaker or Implanted defibrillator
- History of Congestive Heart Failure
- Heart surgery/coronary artery disease

Respiratory:

- Asthma – last ER visit _____
- COPD
- Sleep Apnea
- CPAP/BIPAP
- Tuberculosis – treatment/year _____
- Shortness of breath
- Can you walk a flight of stairs without stopping?

Gastrointestinal:

- Hiatal Hernia
- Acid Reflex (GERD)
- Hepatitis
- Jaundice
- Cirrhosis

Musculoskeletal:

- Arthritis: Rheumatoid or Osteoarthritis
- Back pain or Neck pain
- Difficulty walking

Hematologic:

YES NO

- HIV+
- Anemia/Sickle cell – disease or trait
- Bleeding/Easy bruising
- Blood thinners
- History of blood clots

Genitourinary:

- Kidney Disease
- Dialysis: Hemo/peritoneal (M T W TH F)
- Overactive Bladder/ Incontinence
- Prostate issues
- Ever taken Flomax or Rapaflo, Tamsulosin?

Neurological:

- Stroke or TIA – when _____
- Panic / Depression / Anxiety
- Paralysis – where _____
- Parkinson's disease
- Epilepsy – last seizures _____
- Alzheimer's or Senile Dementia
- Restless Leg Syndrome
- other neurologic condition _____

Females:

- Are you pregnant?
- Last menstrual period _____

Other:

- Problems with Anesthesia
- Cancer- what type _____
- Current treatment _____
- Mastectomy: L or R? When _____
- Do you smoke – how long _____
- Alcohol use – how much _____
- Substance abuse _____
- Have you traveled in past three months?
Where? _____
- Have you or family member had fever with
anesthesia?
- Family Disease History: _____

TURN OVER

Please list all surgeries with approximate dates:

Allergies to medications:

MEDICATION / RESPONSE / SEVERITY

Allergic to: Latex/Rubber _____ Betadine/Iodine _____

Please include all prescriptions, over the counter, vitamins, and dietary supplements:

Medication	Dose	How Often		Medication	Dose	How Often