HEALTH QUESTIONNAIRE

Name _____

PERSONAL PAST HISTORY *Circle "yes" or "no"*

			Year
Cancer	Yes	No	
if "yes", type			
Arthritis	Yes	No	
Back trouble	Yes	No	
Pneumonia	Yes	No	
Asthma	Yes	No	
Emphysema	Yes	No	
Rheumatic fever	Yes	No	
High blood pressure	Yes	No	
Heart disease	Yes	No	
Anemia	Yes	No	
Bleeding tendency	Yes	No	
Hepatitis (yellow)	Yes	No	
Ulcer	Yes	No	
Bladder infections	Yes	No	
Kidney disease	Yes	No	
Hay fever/sinusitis	Yes	No	
Glaucoma	Yes	No	
Diabetes	Yes	No	
Overweight	Yes	No	

Current _____ Desired _____

Last time you were at your desired _____

OPERATIONS

Tonsils	Yes	No	
Appendix	Yes	No	
Gallbladder	Yes	No	
Breast	Yes	No	
Uterus or ovary	Yes	No	
Hemorrhoids	Yes	No	
Heart	Yes	No	
Other	Yes	No	

FAMILY HISTORY (medical problems, cancer, depression,

	Alive	Deceased	Age
Father			
Mother			
Siblings			

PERSONAL HABITS

Have you ever been a smoker? □ Yes □ No
If "yes", what is the most number of packs per day? _____
How old were you when you started smoking? _____
Do you smoke now? □ Yes □ No
If you don't smoke now, age when you quit? _____
Do you use alcohol? □ Yes □ No
If "yes" number of drinks? _____ how often? _____
Have you ever cut down on drinking? □ Yes □ No

OB/GYN

Last normal menstrual period (first day). _____
Length of periods (number of days of bleeding). _____
Number of days between periods? _____
Any recent changes in periods? _____
Are you sexually active? _____
Sexual partners are □ Men □ Women □ Both
Present method of birth control? Pills Tubal Vasectomy
How many pregnancies have you had? _____
How many children do you have? _____ Ages?
Did you nurse? □ Yes □ No How long?
When was your last pap test? _____
What was the result? _____
Have you ever had an abnormal pap test? □ Yes □ No
When was your last mammogram? _____
What was the result? _____
Do you do regular self-breast examinations? □ Yes □ No
Do you have any concerns about your breast exams?

_____
_____
_____

MEDICATIONS, VITAMINS and/or HERBAL REMEDIES

_____
_____
_____

ALLERGIES *circle if you are allergic to:*
Tetanus Penicillin Sulfa Other: _____

IMMUNIZATIONS	Year
Pneumococcal vaccine	
Flu Shot	

ARE YOU?

□ Married □ Single □ In a Long-Term Relationship
□ Divorced □ Widowed

Do you ever feel unsafe at home? □ Yes □ No
Do you work outside of the home? □ Yes □ No
If so, doing what?

Do you exercise? □ Yes □ No ____
Walk, run, bicycle, cross-country ski, weights

****** PLEASE SEE BACK******

Livingston HealthCare
Billings Clinic Affiliate

Patient Label Here

HAVE YOU RECENTLY HAD THE FOLLOWING: Circle "yes" or "no" (if in doubt, leave blank)

General:		
Tires easily, weakness	Yes	No
Weight change	Yes	No
Night sweats	Yes	No
Fever	Yes	No
Sensitivity to heat	Yes	No
Sensitivity to cold	Yes	No
Skin:		
Rash	Yes	No
Change in hair	Yes	No
Change in nails	Yes	No
Eyes:		
Trouble seeing	Yes	No
Eye pain	Yes	No
Ears:		
Loss of hearing	Yes	No
Ringing in ears	Yes	No
Nose:		
Congestion	Yes	No
Nosebleeds	Yes	No
Mouth:		
Sore gums	Yes	No
Soreness of tongue	Yes	No
Dental problems	Yes	No
Throat:		
Postnasal Drip	Yes	No
Soreness	Yes	No
Hoarseness	Yes	No
Breasts:		
Lumps	Yes	No
Discharge	Yes	No
Cardio-Respiratory		
Cough, persistent	Yes	No
Sputum (phlegm)	Yes	No
Wheezing	Yes	No
Chest pain or discomfort	Yes	No
Pain on breathing	Yes	No
Shortness of breath	Yes	No
Difficulty breathing lying down	Yes	No
Swelling of ankles	Yes	No

Cardio-Respiratory Systems (continued)		
High blood pressure	Yes	No
Palpitations	Yes	No
Vein trouble	Yes	No
Digestive System		
Change in appetite	Yes	No
Difficulty swallowing	Yes	No
Heartburn	Yes	No
Abdominal pain	Yes	No
Abdominal swelling	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Rectal bleeding	Yes	No
Tarry stools	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Hemorrhoids	Yes	No
Genitourinary System:		
Increase urinary frequency (day)	Yes	No
Increase urinary frequency (night)	Yes	No
Urge to urinate without much urine	Yes	No
Unable to hold urine	Yes	No
Pain or burning	Yes	No
Blood in urine	Yes	No
Inability to have orgasm	Yes	No
Lack of sex drive	Yes	No
Pain with intercourse	Yes	No
Locomotor:		
Muscle cramps	Yes	No
Muscle weakness	Yes	No
Pain in joints	Yes	No
Nervous System:		
Headaches	Yes	No
Dizziness	Yes	No
Fainting	Yes	No
Nervousness	Yes	No
Sleeplessness	Yes	No
Depression	Yes	No
Suicidal thoughts	Yes	No
Memory loss	Yes	No

Date:_____ **Signature:**_____

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Patient Label Here