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 Arjun Medical Center

History Questionnaire

Name: _____ Date of Birth: _____ Date of visit: _____

Sex: M F Marital Status: _____ Email: _____

Last physical exam: _____ Occupation: _____

Reason for today's visit: _____

Family Health History

Please indicate the major medical conditions past and present of the following biological relatives including heart disease, high blood pressure, diabetes, cancer, etc. If deceased note age and cause.

- Father: _____
- Mother: _____
- Siblings: _____

- Children: _____

Personal Illness

Please indicate if you have had any of the following conditions:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Drug abuse	<input type="checkbox"/> Liver disease, hepatitis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Easy bleeding	<input type="checkbox"/> Measles, mumps, Rubella, or German measles
<input type="checkbox"/> Asthma/emphysema/COPD	<input type="checkbox"/> Eczema, hives, rashes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blood clots/Phlebitis	<input type="checkbox"/> Epilepsy, seizures	<input type="checkbox"/> Suicide attempt
<input type="checkbox"/> Cancer, type: _____	<input type="checkbox"/> Eye problems	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Ulcer in stomach
<input type="checkbox"/> Depression	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	

Immunizations

Circle those that you have had and enter the year of the most recent dose if known.

Flu: _____ Pneumococcal: _____ Prevnar: _____ Shingles: _____ Tetanus: _____

Medication Allergies

Please list the medication and type of reaction for each allergy.

Hospitalization/surgery

List illness or operations and approximate year. Exclude all normal pregnancies.

_____	_____
_____	_____
_____	_____

Medications

List all medications, including birth control, vitamins and other over the counter medications including the doses if known. Use the back of this sheet if needed.

_____	_____
_____	_____
_____	_____
_____	_____

Other Medical History

Current smoker? Yes No Former Smoker? Yes No
If yes, what type: Cigars/Cigarettes How many per day? _____
Start year: _____ End year: _____ or Total # years: _____

Do you drink alcohol? Yes No
If yes, what type? Beer/Wine/Liquor
How much and how often? _____ Daily/Weekly/Monthly

Do you use other drugs? Yes No
Do you drink caffeine? Yes No How many cups per day? _____
Do you exercise? Yes No
What types? _____
How many times per week? _____

For Women Only

of pregnancies _____ # of live born children _____ # of Premature births _____
miscarriages _____ # of still births _____
Date of last Pap smear: _____ Normal/Abnormal
Date of last Mammogram: _____ Normal/Abnormal

Current Symptoms

Please check the symptoms below that currently apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Itchy or burning skin | <input type="checkbox"/> Frequent night time urination |
| <input type="checkbox"/> Dry or flaky skin | <input type="checkbox"/> Black, brown or bloody urine |
| <input type="checkbox"/> Prolonged bleeding | <input type="checkbox"/> Loss of control of urine |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Difficulty starting to urinate |
| <input type="checkbox"/> Fainting or feeling lightheaded | <input type="checkbox"/> Feeling of not completely emptied the bladder |
| <input type="checkbox"/> Numbness in any part of the body | <input type="checkbox"/> Stiff or painful muscles or joints |
| <input type="checkbox"/> Recent changes in handwriting | <input type="checkbox"/> Swollen joint(s) |
| <input type="checkbox"/> Shaking or trembling of hands | <input type="checkbox"/> Changes in bowel movements |

- | | |
|--|---|
| <input type="checkbox"/> Nervous around strangers | <input type="checkbox"/> Bleeding from the rectum |
| <input type="checkbox"/> Difficulty making decisions | <input type="checkbox"/> Back or shoulder pain |
| <input type="checkbox"/> Difficulty with concentration or memory | <input type="checkbox"/> Painful feet |
| <input type="checkbox"/> Often feel lonely or depressed | <input type="checkbox"/> Headaches more than once a week |
| <input type="checkbox"/> Cry often | <input type="checkbox"/> Pain with movement of the neck |
| <input type="checkbox"/> Hopeless outlook | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Sexual difficulties | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Thoughts of committing suicide | <input type="checkbox"/> Hearing difficulty |
| <input type="checkbox"/> Desired or sought psychiatric help | <input type="checkbox"/> Motion sickness in cars or planes |
| <input type="checkbox"/> Weight loss or gain | <input type="checkbox"/> Dental problems |
| <input type="checkbox"/> Are you often too hot or too cold? | <input type="checkbox"/> Changes in taste |
| <input type="checkbox"/> Decreased interest in eating | <input type="checkbox"/> Stuffy or runny nose |
| <input type="checkbox"/> Do you always seem to be hungry? | <input type="checkbox"/> Head cold for 2 or more months |
| <input type="checkbox"/> Increased thirst | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Swellings in your armpits or groin | <input type="checkbox"/> Sore throat without a cold |
| <input type="checkbox"/> Are you exhausted or fatigued most of the time? | <input type="checkbox"/> Enlarged tonsils |
| <input type="checkbox"/> Difficulty falling or staying asleep | <input type="checkbox"/> Hoarse voice |
| <input type="checkbox"/> Snore at night | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Wake up still tired after a full night of sleep | <input type="checkbox"/> Coughing spells |
| <input type="checkbox"/> Frequently sleep during the day | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Fall asleep quickly at night | <input type="checkbox"/> Frequent sweating or night sweats |
| <input type="checkbox"/> Teeth grinding during sleep | <input type="checkbox"/> High blood pressure now or in the past |
| <input type="checkbox"/> Frequent kicking or movements during sleep | <input type="checkbox"/> Thumping or racing heart |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Chest pain or tightness |
| <input type="checkbox"/> Feel bloated after eating | <input type="checkbox"/> Dizziness or lightheadedness |
| <input type="checkbox"/> Frequent belching | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Stomach discomfort | <input type="checkbox"/> Waking up at night feeling short of breath |
| <input type="checkbox"/> Frequently nauseated | <input type="checkbox"/> Swollen feet or ankles |
| <input type="checkbox"/> Ever vomited blood | <input type="checkbox"/> Leg cramps at night or with walking |
| <input type="checkbox"/> Difficult or painful swallowing | <input type="checkbox"/> Heart murmur |

Men only	Women Only
<input type="checkbox"/> Weak or slow urine stream	<input type="checkbox"/> Bleeding after menopause
<input type="checkbox"/> Enlarged prostate or other prostate problems	<input type="checkbox"/> Heavy bleeding with periods
<input type="checkbox"/> Burning or discharge from the penis	<input type="checkbox"/> Bleeding between periods
<input type="checkbox"/> Swelling or lumps in the testicles	<input type="checkbox"/> Bleeding after intercourse
<input type="checkbox"/> Painful testicles	<input type="checkbox"/> Vaginal itching or discharge
<input type="checkbox"/> Difficulty getting or maintaining an erection	<input type="checkbox"/> Lumps or pain in breasts
	<input type="checkbox"/> Complications with birth control
	<input type="checkbox"/> Sexual difficulties
	<input type="checkbox"/> Abnormal Pap smears or mammogram