Patient Health History Questionnaire Instruction Sheet

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Please print all information

Patient Name – print your full name (e.g. Susan B. Allen)
Date – use the date you are completing the form (e.g. 7-8-00)
Occupation – if retired, please state what you did before you retired
Ethnic Origin – e.g. African American, Hispanic, Arabic, Indian, etc. (This question is used to identify risk factors associated with specific ethnic groups)
Emergency Contact – Provide a name and telephone number of someone we can contact if we need to reach you in an emergency situation. It should be someone that is not living at your household.
Release of Information –

If you do not want us to give out or discuss your medical information to anyone other than you (e.g. appointment times, test results, etc.) place an "X" next to "No One"

If it is okay to give out or discuss your medical information to: Spouse - write his/her name next to "Spouse"
Other – write their name(s) under "Other" (this could be a parent, child(ren), special friend, sister, brother, etc.) and their relationship to you.

Permission to leave messages with whoever answers your home phone number or on your answering machine concerning test results, appointment times/dates and/or procedure results,

If it is okay to leave messages, place an "X" in the space provided.
If it is not okay to leave messages, write "NO" in the space provided.

Immunizations –
If you have had the immunization listed, place an "X" under "Yes",
If you know the year it was given, write the year under "Year"
If you are unsure if you've had the immunization, or unsure about the date, place an "X" under "Unsure"
If you have never had the immunization, place an "X" under "Never"

Personal/Family History –

Self - place an "X" under the "Self" column if you have ever had the condition listed. If you know when this condition started, place the year, under the "Year" column

Family - place an "X" under the "Family" column if any member of your family ever had the condition listed. Under the "Who" column write in "F" for father, "M" for mother, "S" for sister or brother, "GP" for grandparent.

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Examinations

If you have had the test/procedure listed, place an "X" under "Yes",

If you know the year it was last done, write the year under "Year"

If you are unsure if you've had the test/procedure, or unsure about the date, place an "X" under "Unsure"

If you have never had the test/procedure, place an "X" under "Never"

Notes/Complications – include allergies to dyes given, abnormal results, abnormal findings, etc.

Personal Habits –

Please answer honestly.

This information is needed to assure the best possible treatment.

All information is confidential.

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Operations

Date – write in date of operation

Comments – list specific information about operation

Hospitalizations – List each hospitalization, the reason for the hospitalization, the year you were hospitalized and the hospital you were in.

Recurrent Problems – list problems that you are having that you seek medical treatment of, e.g. heart disease, diabetes, tendonitis, high blood pressure, etc.

Allergies

List all allergies to medicine including your reaction when you took the medicine, e.g. rash, hives, upset stomach, etc.

List all allergies to other substances such as plastic tape, latex, foods. Again, list what reaction you have to these substances.

If you are not allergic to any medications place an "X" in the box that says "No Know Medication Allergies.

Medications - Using your prescription medication bottle, list the name of each medication you take, the dosage (in milligrams if possible) and how often you take the medication. Be sure to include over the counter medications, herbal medication such as ginseng and medications you do not take on a regular basis.

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Other Information

DEFINITIONS

Anemia – Anemic, low blood count
Back Disorders – lumbago, abnormal curves to spine, slipped or ruptured disk
Bleeding Diseases – hemophilia
Colitis – inflammation of the colon
Freq. Urination at night – have to get up several times during the night to urinate
Gallstones – stones in your gallbladder
GI Bleeding – vomiting blood, blood in stools
Glaucoma – increased pressure in eyeball
Hepatitis – inflammation of the liver
Nervous Disorder – panic attacks, depression, etc.
Paralysis – unable to move a portion of your body, leg, arm, facial muscles
Phlebitis - irritation or inflammation of the blood vessels
Pleurisy – inflammation of the lining of the lungs