



**TRIPLE O MEDICAL
SERVICES P.A.**

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Health History Questionnaire

All questions contained within this questionnaire are strictly confidential and will become a part of your medical record.

List any diagnosed medical problems		

Surgeries		
Year	Reason	Hospital

Other Hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	<input type="checkbox"/> NO	<input type="checkbox"/> YES
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List your prescribed drugs and over-the-counter medications, including vitamins and inhalers		
Name of Drug	Strength	Frequency Taken

Allergies to Medications	
Name of Drug	Reaction

WOMEN ONLY	
Age of onset of menstruation:	
Date of last menstruation:	
Period every _____ days	
Heavy periods, irregularity, spotting, pain or discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of pregnancies: _____ Number of live births _____	
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a D&C, hysterectomy or Cesarean?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any urinary tract, bladder or kidney infection within the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any hot flashes or night sweats?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability or other symptoms around your period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Experienced any breast tenderness, lumps or nipple discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last pap and rectal exam?	

MEN ONLY	
Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, how many times:	
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel burning discharge from the penis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any kidney, bladder or prostate infection in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any difficulty with ejaculation or erection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last prostate and rectal exam?	

Other Problems		
Check if you have, or have had any symptoms in the following areas to a significant degree. Please explain		
<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy Level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

Family History		
Check if anyone in your family has any of the following conditions. Please explain		
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/>
<input type="checkbox"/> Cancer	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/>
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Genetic Disorder	<input type="checkbox"/>
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH HABITS AND SOCIAL HISTORY		
ALL QUESTIONS CONTAINED HERE ARE OPTIONAL AND ARE STRICTLY CONFIDENTIAL		
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola	
	# of cups/cans per day?	
Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?	
	How many drinks per week?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you concerned about the amount you drink?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – packs per day <input type="checkbox"/> Chew - #/ day <input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day	
	<input type="checkbox"/> # of years <input type="checkbox"/> or year quit	
Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself drugs with a needle?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Travel	Have you ever traveled outside of the United States?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you traveled within the past 5 years outside of the United States?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes to above, where?	
Home	Do you have pets at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex	Are you sexually active?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you trying for pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If not trying for pregnancy, list contraceptive or barrier method:	
	Any discomfort with intercourse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Illness related to HIV, such as AIDS, has become a major public health problem. Risk factors for this include intravenous drug use and unprotected sexual intercourse. Would you like to speak to your provider about your risk for this illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No

MENTAL HEALTH	
Is stress a major problem for you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes <input type="checkbox"/> No