East Bay Medical Center

1401 Short Drive, PO BOX 19, Prudenville, MI 48651

Health History Questionnaire

Name: _____

Age: _____ **DOB:** _____ **Today's Date:** _____

Reason for Visit: _____

_____

_____

_____

Allergies: (Food, Medications, Environmental) please list reaction

_____

_____

_____

Medications: (including OTC, Vitamins, Inhalers)

Name	Dosage	Frequency

Diabetics Supplies: How often testing, what type of monitor and strips, Diabetic Supply Company

_____

_____

Pharmacy Used: (local and Mail-in if applicable)

_____

Past Medical History:

Constitutional
- __Chills
- __Fever
- __Weight Gain
- __Weight Loss
- __Fatigue

HEENT:
- __Double Vision
- __Ear Infection
- __Eye Pain
- __Nasal Congestion
- __Sore Throat
- __Sinus Infection
- __Have seen an ENT Specialist

Respiratory:
- __Shortness of Breath at Rest
- __Shortness of Breath w/ Activity
- __Wheezing
- __Frequent Cough
- __Severe Chest Pain
- __Asthma
- __Snoring
- __Have seen a Pulmonologist

Cardiovascular:
__Chest Pain
__Edema/Swelling
__Palpitations
__A-Fib
__Bradycardia
__Tachycardia
__Pacemaker
__Defibrillator
__Abnormal EKG
__Hypertension
__ Hypotension
__ Have seen a Cardiologist

Gastrointestinal:
__Abdominal Pain
__Change in Bowel Habits
__Constipation
__Diarrhea
__Heartburn/GERD
__Vomiting of Blood
__Blood in Stool
__Loss of Appetite
__Nausea
__Vomiting
__Have seen a GI Specialist

Genitourinary:
__Painful Urination
__Blood in Urine
__Urinary Frequency
__Urinary Incontinence
__Urinary Retention
__Prostate Problems
__Hx of Catheterization
__Kidney Stones
__Kidney Disease
__ Have seen a Urologist or Nephrologist

Reproductive:
__Breast Lumps
__Breast Pain
__Vaginal Discharge
__Penile Discharge
__Sexual Dysfunction
__History of STD's
__Erectile Dysfunction
__Have seen a Urologist or Gynecologist

Metabolic/Endocrine:
__Cold Intolerance
__Excessive Thirst
__Heat Intolerance
__Enlarged Breast In Men
__Diabetes Mellitus Type I
__Diabetes Mellitus Type II
__Thyroid Disease
__Have seen an Endocrinologist

Neurological:
__Dizziness
__Headache
__Numbness
__Tremors
__Stroke/TIA
__Memory Loss/Dementia
__Alzheimer's Disease
__Multiple Sclerosis
__Gait Abnormality
__Have seen a Neurologist

Psychiatric:
__Anxiety
__Depression
__Increased Stress
__Panic Attacks
__PTSD
__Have seen a Therapist
__Alcohol/Drug Abuse

Integumentary:
__Contact Allergy
__Hives
__Rash
__Eczema
__Psoriasis
__Skin cancer
__Have seen a Dermatologist

Musculoskeletal:
__Chronic Back Pain
__Acute Back Pain
__Joint Pain/Arthritis
__Muscle Pain
__Hx of Fracture
__Have seen an Orthopedic or Neurosurgeon

Hematologic/Lymphatic:
__Easy Bleeding
__Easy Bruising
__Swollen Lymph Nodes
__Clotting Disorder
__Taking Coumadin
__Lupus
__Rheumatoid Arthritis
__Have seen a specialist

Immunologic:
__Asthma
__Chemicals in Work Place
__Immunosuppression
__Seasonal Allergies
__Have seen an Allergist

Cancer:
Type _____
Year Diagnosed _____
Treatment _____
_____
Oncologist_____

Any other medical conditions not listed above:

_____
_____
_____
_____

Surgical History: please include any arthroscopic, heart cath, colonoscopies, biopsies etc.

Procedure Year Surgeon Facility

Imaging: CT, MRI, X-rays. Please include facility and reason for Imaging

Social History:

Marital Status:_____ Children: _____

Occupation: _____

Smoking History:

__Current Everyday Smoker __Current Occasional Smoker __Never Smoker

___PPD ___Years Smoked __Year Quit

Alcohol Use:

__ Current Everyday Drinker __Occasional Drinker __Never Drinks

__Drinks Caffeine ____Cups Per Day

__Recreational Drug Use Type and How long: _____

__Exercises Daily __Exercises Occasionally __Never Exercises

__Wears Seatbelt

Family History: If any history of cancer please list which type

Mother: _____

Father: _____

Sister(s): _____

Brother(s): _____

Maternal Grandfather: _____

Maternal Grandmother: _____

Paternal Grandfather: _____

Paternal Grandmother: _____

Child(ren): _____

Any other significant family history: