

ERIC M. GROSS, M.D., F.A.C.S

HEALTH HISTORY QUESTIONNAIRE

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

Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Previous or referring doctor:		

PERSONAL HEALTH HISTORY

List any current medical problems.

List any past medical problems.

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Allergies to medications

Name the Drug	Reaction You Had

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HEALTH HABITS AND PERSONAL SAFETY

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Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/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 street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS (TYPE OF ILLNESS/DISEASE)		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
Mother				<input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		

COMMUNICABLE DISEASES

HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis A, B, C If yes specify which type.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HPV	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Syphilis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chlamydia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other: (specify)	<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 have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No