1011 State St. Suite 120, Lemont, IL 60439

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First, M.I.):*		
DOB:	**Height:**	**Weight:**

MEDICAL HISTORY – PLEASE PROVIDE A BRIEF EXPLANATION FOR THE MEDICAL CONDITIONS WHICH APPLY TO YOU.			
Condition	**No**	**Yes**	**Explanation**
Arthritis			
Asthma			
Bleeding/Blood Disease			
Cancer			
Diabetes			
Heart Disease/Murmur			
High Blood Pressure			
Kidney/Urinary disease			
Liver problems/Hepatitis			
Nervous disorders			
Seizures or Epilepsy			
Thyroid Disorders			
Other			
Are you pregnant? If yes, how many months?			

SURGERIES		
Year	Reason	Hospital

Currently, do you have any of the following symptoms? (Please mark those that apply)					
	Seasonal allergies		Ringing in the ear(s)		Snoring
	Cough		Hearing loss		Nosebleed
	Shortness of breath		Dizziness		Problems swallowing
	Fever		Facial pain		Heartburn or indigestion
	Weight loss		Nasal congestion		Swollen glands
	Rash on skin		Nasal drainage		Bruise or bleed easily
	Temperature intolerance		Sore throat		Muscle or joint pain
	Ear pain		Hoarseness		Headache
	Ear drainage		Lumps or nodules (where?)		Numbness/Weakness
	Ear blockage		Excessive daytime tiredness		Visual disturbances

(2 SIDES)

List your Medications (including prescribed drugs and over-the-counter drugs, such as vitamins and inhalers)		
Name the Drug	Strength	Frequency Taken

Allergies to medications?	☐	Yes	☐	No

If yes, Name the Drug	Reaction You Had

Have you received an influenza (flu) shot?	☐	Yes	☐	No

If yes, when did you get it?	Where did you get it?

HEALTH HABITS AND PERSONAL SAFETY							
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.							
Alcohol	Do you drink alcohol?	☐	Yes	☐	No		
	If yes, what kind?						
	Most number of drinks per day?		How many times a week do you drink?				
Tobacco	Do you use tobacco?	☐	Yes	☐	No		
	☐ Cigarettes – pks./day	☐ Chew - #/day		☐ Pipe - #/day		☐ Cigars - #/day	
	☐ # of years	☐ Or year quit					

FAMILY HISTORY—PLEASE PROVIDE A BRIEF EXPLANATION FOR THE MEDICAL CONDITIONS WHICH APPLY TO YOUR FAMILY						
Condition	**Dad**	**Mom**	**Sibling**	**Child**	**Other**	**Explanation**
Arthritis						
Asthma						
Bleeding/Blood Disease						
Cancer						
Diabetes						
Heart Disease/Murmur						
High Blood Pressure						
Kidney/Urinary disease						
Liver problems/Hepatitis						
Nervous disorders						
Seizures or Epilepsy						
Thyroid Disorders						
Other						