Jonathan T. Paine, M.D.
Health History Questionnaire

Patient Name: _____ Date of Birth: _____ Ht.: _____ Wt.:_____ (Lbs.)
Today's Date: _____
Dominant Hand (Circle One): Right Left Both

Current Medications: (When listing medications include all over-the-counter medications and naturopathic supplements)

Medication Name (Including Strength)	Dosage/Frequency	Route of Administration (Oral, injection, etc.)	Reason Taking Medication

Pharmacy(s) Name(s) and Address(es): Include phone number if possible:
_____
_____

List Allergies to Medications and Foods (Include Reaction)
_____
_____
_____

When was your last flu vaccine? Month_____ Year _____

Habits:

Do you smoke? (Circle one)		Yes	No
If yes,	Cigarettes?	Yes	No
	Cigars?	Yes	No
	Pipes?	Yes	No
If cigarette smoker:	How many packs per day?		_____
	Year started		_____
	Number of years smoked?		_____
If cigar smoker:	How many per week?		_____
	Year started		_____
	Number of years smoked?		_____
If pipe smoker:	How many pipes per week?		_____
	Year started		_____
	Number of years smoked?		_____

If former cigarette smoker, how many packs per day? _____ Year started: _____ Number of years smoked _____
Year quit: _____ Number of years since last quit: _____
If former cigar smoker, how many per week? _____ Year started: _____ Number of years smoked _____
Year quit: _____ Number of years since last quit: _____
If former pipe smoker, how many per week? _____ Year started: _____ Number of years smoked _____
Year quit: _____ Number of years since last quit: _____
Do you currently use smokeless tobacco? (Circle one) Yes No. If yes, how many times per day _____
Year started _____ Number of years used _____
Did you formerly use smokeless tobacco? (Circle one) Yes No. If yes, how many times per day _____
Year started _____ Year quit _____ Number of years since last quit _____ Number of years used _____

Are you exposed to passive smoke (Circle one) Yes No

Do you use recreational drugs? (Circle one) Yes No
If yes, list substance(s) _____

Average number of caffeinated beverages per day: _____

Do you drink alcoholic beverages (Circle one) Yes No
If yes, type: (i.e. beer, wine, liquor) _____
Number of drinks per day: _____
If yes, have you ever:

Felt the need to cut down?	Yes	No
Felt annoyed by complaints about your drinking?	Yes	No
Felt guilty about drinking?	Yes	No
Felt the need for an "eye opener" in the morning?	Yes	No
Been counseled to quit or cut down	Yes	No

Do you exercise? Yes No
If yes, how many times per week? _____
Type of exercise _____

What percent of the time do you wear a seatbelt:
Circle one: 100% 75% 50% 25%

Sun exposure: Circle one Frequent Occasional Rare Remote

Women only: Number of pregnancies _____ Number of Children _____ Date of last menstrual period _____

Do you have a family history (immediate family only) of heart attack? Yes No

If yes, Female under age 65? Yes No _____ Relationship
If yes, Male under age 55? Yes No _____ Relationship

Patient Name (Print)_____
Date: _____

Major Illnesses:

- High blood pressure Yes No
- Diabetes Yes No
- Heart problems Yes No
  If yes, what type? _____
  Name of cardiologist: _____
  Pacemaker? Yes No
- Have you been diagnosed with sleep apnea? Yes No
  (If yes, please provide this office with the most recent sleep study)
  Do you use a CPAP machine? Yes No

- Have you had a stroke or new onset seizure
  within the last 3 months? Yes No
  (If yes, please provide this office with the most recent exam note from your neurologist)
- Are you undergoing renal dialysis? Yes No
  Name of treating physician _____
  Name of dialysis center _____

List types of surgeries and approximate date:

_____
_____
_____
_____
_____

List major accidents/injuries or trauma and approximate date. (Please include concussive injuries)

_____
_____
_____
_____
_____

Family History

	Major Health Problems	Age at Death	Cause of death if known
Father			
Mother			
Brother/Sister			
Brother/Sister			
Brother/Sister			

Patient Name (Print)_____
Date: _____

Health History Systems Review
Please place an "x" on all conditions that apply

GENERAL
□ fever
□ chills
□ sweats
□ anorexia
□ fatigue
□ weakness
□ malaise
□ weight loss
□ sleep disorder
Comments:

EYES
□ blurring
□ double vision
□ irritation
□ discharge
□ vision loss
□ eye pain
□ light sensitivity
Comments:

EARS/NOSE/THROAT
□ earache
□ ear discharge
□ ringing in ears
□ decreased hearing
□ nasal congestion
□ nosebleeds
□ sore throat
□ hoarseness
Comments:

CARDIOVASCULAR
□ chest pain
□ palpitations
□ fainting episodes
□ difficulty breathing
□ shortness of breath when lying flat
□ waking from sleep unable to breath
□ swelling of lower legs/feet
Comments:

RESPIRATORY
□ cough
□ difficulty breathing
□ excessive sputum
□ coughing up blood
□ wheezing
□ chest pain with breathing/coughing
Comments:

GASTROINTESTINAL
□ nausea
□ vomiting
□ diarrhea
□ constipation
□ change in bowel habits
□ abdominal pain
□ black, tarry stool
□ rectal bleeding
□ yellow skin discoloration
□ gas/bloating
□ indigestion/heartburn
□ difficulty swallowing
□ painful swallowing
Comments:

GENITOURINARY
□ painful urination
□ blood in urine
□ discharge
□ urinary frequency
□ urinary hesitancy
□ nighttime urination
□ incontinence
□ genital sores
□ decreased libido
□ erectile dysfunction
□ vaginal discharge
□ absence of menstruation
□ heavy or prolonged menstrual periods
□ abnormal vaginal bleeding
□ pelvic pain
Comments:

MUSCULOSKELETAL
□ back pain
□ joint pain
□ joint swelling
□ muscle cramps
□ muscle weakness
□ stiffness
□ arthritis
□ sciatica
□ restless legs
□ leg pain at night
□ leg pain with exertion
Comments:

DERMATOLOGICAL
□ rash
□ itching
□ dryness
□ suspicious lesions
Comments:

NEUROLOGICAL
□ paralysis
□ tingling, numbness or burning in extremities
□ seizures
□ tremors
□ sensation of room spinning
□ transient blindness
□ frequent falls
□ frequent headaches
□ difficulty walking
Comments:

PSYCHOLOGICAL
□ depression
□ anxiety
□ memory loss
□ thoughts of suicide
□ hallucinations
□ paranoia
□ phobia
□ confusion
Comments:

ENDOCRINE
□ cold intolerance
□ heat intolerance
□ excessive thirst
□ excessive hunger
□ excessive urination
□ unusual weight change
Comments:

HEMATOLOGICAL
□ abnormal bruising
□ bleeding
□ enlarged lymph nodes
Comments:

ALLERGY
□ hives
□ allergic rash
□ hay fever
□ recurrent infections
Comments:

_____
Patient Name (Print)

_____
Patient Signature

_____
Date

_____
Parent, guardian or legal representative signature

_____
Relationship
Date