Khan Geriatric & Internal Medicine
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Patient Health History Questionnaire

Patient Name: _____ Date: _____
Birth Date: _____ Age: _____ Sex: Female or Male

What is your chief complaint or main reason for your visit today? _____

How did you hear about our office or who referred you to our office? _____

Medical Conditions: Please circle any conditions that you currently experience or have experienced in the past:

Gout	Heart Arrhythmia	Emphysema/COPD	Seizures
Anemia	Heart Attack	Kidney Problem	Sexually Transmitted Ds
Arthritis	Heart Failure	Kidney Stones	Stroke
Cancer	Hepatitis	Migraine Headaches	Thyroid Problems
Pneumonia	Depression/Anxiety	High Cholesterol	Tuberculosis
Diabetes	Hypertension	Rheumatic Fever	Ulcers

Symptoms: Please circle any symptoms that you currently have or had in the last year:

Fever	Chills	Sweating	Weight Loss or Gain	Fatigue
Ear Ache	Hay Fever	Cough	Bleeding Gums	Blurry Vision
Sputum	Hoarseness	Hearing Loss	Trouble Swallowing	Sinus Congestion
Ringing Ears	Nosebleeds	Chest Pain	Palpitations	Leg Swelling
Heartburn	Constipation	Diarrhea	Abdominal Pain	Loss of Appetite
Nausea	Vomiting	Hemorrhoids	Rectal Bleeding	Black Stool
Wheezing	Numbness	Joint Pain	Short of Breath	Back Pain
Joint Swelling	Dizziness	Blood in Urine	Loss of Urine	Burning with Urination
Headache	Fainting	Increased Urine Freq	Change in Mole	Hives
Itching	Rash	Excess Thirst	Easy bruising	Trouble Sleeping

Surgeries & Hospitalizations:

Please list all surgeries & the year it occurred: _____

Please list recent hospitalizations & dates: _____

Family History:

Please list if relative is living or deceased, current age or age at death, cause of death & any other significant medical problems:

Relative	Living/Deceased	Age	Cause of Death/Problem
Mother			
Father			
Siblings			

Are there any other hereditary medical conditions we should be aware of? _____

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OB/GYN History: (Please skip this part if you are a male)

Number of pregnancies: _____ Any complications: _____
Is there a chance that you are pregnant today? _____

Social History:

Marital status or living arrangement: _____
Current employer & occupation: _____
Any hazardous occupational exposures? _____ If so, what kind? _____
Level of education? _____ Pertinent sexual history? _____

Health Habits

Do you currently or have you ever used tobacco products? _____
If yes, what form of tobacco? _____
If yes, how many years have you used tobacco? _____
If yes, how much do you use on a daily basis? _____
Do you drink alcohol in any form? _____ How much? _____
Do you drink caffeine in any form? _____ How much? _____
Do you use any recreational drugs? _____ What kind & how much? _____

Screening & Preventative Medicine Issues: Please list the date that you last had the following completed

Flu Shot _____ Tetanus Shot _____ Pneumonia Shot _____ Colonoscopy _____
Ekg _____ Pap Smear _____ Rectal/Stool Test _____
Eye Exam _____ Mammogram _____ Cholesterol Test _____

Allergies

Please list any allergies & the reaction you had: _____
_____

Medications: List all medications you are currently taking with dose & frequency (or provide a medication list)

_____
_____
_____
_____

What is your local pharmacy name, address & phone number? _____
_____
What is your mail away pharmacy name, phone & fax number? _____
_____

What other physicians or specialists are you currently seeing? _____
_____

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Are there any other issues that you feel would be important for us to know to better serve you as a patient? _____

_____

If applicable, please list the name, phone number & relationship of your healthcare surrogate:

_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any other members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient Signature Date

_____ _____

Reviewed by (clinical staff) Date