WALK-IN HEALTH HISTORY QUESTIONNAIRE

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

Patient Name: *Last* *First* *MI*

Today's Date: **Reason for Visit**:

Previous or referring doctor:	**Patient sex :** ☐ **M** ☐ **F**	**DOB:**

PERSONAL HEALTH HISTORY (PAST MEDICAL HISTORY)

Conditions you have had in the past (check all that apply):

☐ AIDS/HIV +	☐ Bulimia	☐ Goiter	☐ Liver Disease	☐ Stroke
☐ Alcoholism	☐ Cancer	☐ Gonorrhea	☐ Migraine Headache	☐ Suicide Attempt
☐ Anemia	☐ Cataracts	☐ Gout	☐ Mononucleosis	☐ Thyroid Problems
☐ Anorexia	☐ Chem Dependancy	☐ Heart Disease	☐ Multiple Sclerosis	☐ TB
☐ Arthritis	☐ Chicken Pox	☐ Hepatitis	☐ Pneumonia	☐ Ulcers
☐ Asthma	☐ Diabetes	☐ Hernia	☐ Polio	LIST ANY OTHERS
☐ Bleeding Disorders	☐ Emphysema	☐ Herpes	☐ Prostate Problem	☐
☐ Breast Lump	☐ Epilepsy	☐ High Cholesterol	☐ Rheumatic Fever	☐
☐ Bronchitis	☐ Glaucoma	☐ Kidney Disease	☐ Scarlet Fever	☐

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

Do you know your blood type? ☐ Yes ☐ No Type:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Drug Name	Strength	Frequency Taken	**Drug Name**	Strength	Frequency Taken
1			9		
2			10		
3			11		
4			12		
5			13		
6			14		
7			15		
8			16		

Allergies to medications

Drug Name	**Reaction You Had**	**Drug Name**	**Reaction You Had**
1		3	
2		4	

PATIENT NAME: ____ **DATE OF BIRTH:** ______________________

Review Of Systems (check all that apply to you)

CONSTITUTIONAL
- ☐ Wt. loss or gain
- ☐ Fever
- ☐ Fatigue
- ☐ Chills

EYES
- ☐ Blurry vision
- ☐ Double vision
- ☐ Vision changes
- ☐ Cataracts
- ☐ Glaucoma

ENT/MOUTH
- ☐ Sinus problems
- ☐ Runny nose
- ☐ Tooth pain
- ☐ Hearing loss
- ☐ Ringing ears
- ☐ Gum pain
- ☐ Gum bleeding
- ☐ Swallowing difficulties
- ☐ Ear pain
- ☐ Ear discharge

ALLERGY/IMMUNO
- ☐ Rashes/hives/wealts
- ☐ Itchiness
- ☐ Allergic asthma/bronchitis

NEURO
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Headache
- ☐ Lack of coordination
- ☐ Balance problems
- ☐ Seizures
- ☐ Numbness

PSYCH
- ☐ Depression
- ☐ Mood swings
- ☐ Memory problems
- ☐ Anxiety

ENDO
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Hair loss
- ☐ Nail changes
- ☐ Night sweats
- ☐ Hot flashes

SKIN
- ☐ Skin rashes
- ☐ Bruising
- ☐ Changes in skin lesions
- ☐ Wounds
- ☐ Ulcers

GENITOURINARY
- ☐ Burning urination
- ☐ Excessive urination
- ☐ Incontinence of urine
- ☐ Blood in urine
- ☐ Frequent bladder/kidney infections
- ☐ History of sexually transmitted disease

GASTROINTESTINAL
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Incontinence of bowels
- ☐ Blood in stools
- ☐ Bloating
- ☐ Poor appetite
- ☐ Hemorrhoids
- ☐ Nausea

HEM/LYMPH
- ☐ Bruising
- ☐ Nosebleeds
- ☐ Lack of energy

RESPIRATORY
- ☐ Frequent lung infections
- ☐ Shortness of breath
- ☐ Chest tightness
- ☐ Wheezing
- ☐ Sleeping problems
- ☐ Persistent cough
- ☐ Asthma

CARDIOVASCULAR
- ☐ History of Rheumatic fever
- ☐ Palpitations
- ☐ Chest pain
- ☐ Swelling hands
- ☐ Swelling feet
- ☐ Irregular heart beat
- ☐ High or low blood pressure

MUSC/SKELETAL
- ☐ Difficulty walking
- ☐ Joint stiffness
- ☐ Muscle pains
- ☐ Back pain
- ☐ Pain during walking

Is there anything else you would like to discuss with the doctor?

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I have reviewed this history with the patient for accuracy and completeness:

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Physician signature and date