Personal Details

Name:
Address:
Home Phone:
Cell Phone:
Date Of Birth:
Age:
Occupation:
Email:

Weight History

Please Indicate Your Weight At The Following Times. Please Indicate Whether You Consider Your Weight Was Below Average (BE), Above Average (AA), Or Very Heavy (VH).

Birth Weight:
Weight At Starting School (5-6 Years):
Weight At Beginning Of High School (10- 12 Years):
Weight At End OI High School (15-18 Years):
Weight At The Time Of Commencing Work (21 Years):
Weight At Time Of Marriage (If Applicable):
Current Weight:
Height:
BMI:

Referral Information

Referring person:
Date Of Referral:
Phone Contact:
SURGERY SUGGESTED DATE:
☐

Emergency contact

Name:
Relationship:
Address:
Home Phone:
Cell Phone:

Fax # (619)839-3641
Cell # (626)327-2488

FOR HOSPITAL USE ONLY		Original Date:	
		Dates Revised:	
Last Name	First Name	April 2011	
DOB:		File No.	

Bar Code

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.): ☐ M ☐ F DOB:
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Previous or referring doctor: Date of last physical exam:

Current height ( )ft. ( )in. / ( )cm Current weight ( )lbs / ( )kg

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR Measles, Mumps, Rubella

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

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

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

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL					
Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e, climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e work or recreation, less than 4x/week for 30 min)				
	☐ Regular vigorous exercise (i.e, work or recreation 4x/week for 30 min)				
Diet	Are you di8eting?			☐ Yes	☐ No
	If yes, are you on a physical prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				

Alcohol	**Do you drink alcohol?**	☐ Yes	☐ No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?	☐ Yes	☐ No
	Have you considered stopping?	☐ Yes	☐ No
	Have you ever experienced blackouts?	☐ Yes	☐ No
	Are you prone to "binge" drinking?	☐ Yes	☐ No
	Do you drive after drinking?	☐ Yes	☐ No
Tobacco	**Do you use tobacco?**	☐ Yes	☐ No
	☐ Cigarettes pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day		
	☐ # of years ☐ Or year quit		
Drugs	**Do you currently use recreational or street drugs?**	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Sex	**Are you sexually active?**	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used?		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	**Do you live alone?**	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

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www.affordablewls.com

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling				☐ M ☐ F	
				☐ M ☐ F	
	☐ M ☐ F		**Grandmother** Maternal		
	☐ M ☐ F		**Grandfather** Maternal		
	☐ M ☐ F		**Grandmother** Paternal		
	☐ M ☐ F		**Grandfather** Paternal		

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of your urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	