

UT Southwestern Medical Center

Health History Questionnaire

Pt. Name: _____

Address: _____

City

State

Zip

MRN: _____

DOB: _____ SEX: _____

Allergies:

Medication or Substance

Reaction

_____	_____
_____	_____
_____	_____
_____	_____

Current Medications and Over-the-Counter Medicines:

Name

Dose

Frequency

<u>Name</u>	<u>Dose</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History:

	Yes	No	Date First Noted (approximately)	Comments
Allergies	<input type="radio"/>	<input type="radio"/>		
Anemia	<input type="radio"/>	<input type="radio"/>		
Angina	<input type="radio"/>	<input type="radio"/>		
Anxiety Disorder	<input type="radio"/>	<input type="radio"/>		
Arthritis	<input type="radio"/>	<input type="radio"/>		
Asthma	<input type="radio"/>	<input type="radio"/>		
Atrial Fibrillation	<input type="radio"/>	<input type="radio"/>		
Bowel Disease	<input type="radio"/>	<input type="radio"/>		
Breast Cancer	<input type="radio"/>	<input type="radio"/>		
Colorectal Cancer	<input type="radio"/>	<input type="radio"/>		
Congestive Heart Failure	<input type="radio"/>	<input type="radio"/>		
Chronic Obstructive Pulmonary Disease (COPD)	<input type="radio"/>	<input type="radio"/>		
Coronary Artery Disease	<input type="radio"/>	<input type="radio"/>		



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Medical History (continued):

	Yes	No	Date First Noted (approximately)	Comments
Depression	<input type="radio"/>	<input type="radio"/>		
Diabetes Type 1	<input type="radio"/>	<input type="radio"/>		
Diabetes Type 2	<input type="radio"/>	<input type="radio"/>		
Diverticulitis	<input type="radio"/>	<input type="radio"/>		
Gallbladder Disease	<input type="radio"/>	<input type="radio"/>		
Gastric Ulcers	<input type="radio"/>	<input type="radio"/>		
GERD	<input type="radio"/>	<input type="radio"/>		
Heart Attack/MI	<input type="radio"/>	<input type="radio"/>		
Hepatitis	<input type="radio"/>	<input type="radio"/>		
High Cholesterol	<input type="radio"/>	<input type="radio"/>		
Hypertension	<input type="radio"/>	<input type="radio"/>		
Hyperthyroid Disease	<input type="radio"/>	<input type="radio"/>		
Hypothyroid Disease	<input type="radio"/>	<input type="radio"/>		
Refuses Blood Products	<input type="radio"/>	<input type="radio"/>		
Lung Cancer	<input type="radio"/>	<input type="radio"/>		
Memory Loss	<input type="radio"/>	<input type="radio"/>		
Migraines	<input type="radio"/>	<input type="radio"/>		
Multiple Sclerosis	<input type="radio"/>	<input type="radio"/>		
Osteoporosis	<input type="radio"/>	<input type="radio"/>		
Prostate Disease	<input type="radio"/>	<input type="radio"/>		
Renal Disease	<input type="radio"/>	<input type="radio"/>		
Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>		
Seizures	<input type="radio"/>	<input type="radio"/>		
Sickle Cell Anemia	<input type="radio"/>	<input type="radio"/>		
Sleep Apnea	<input type="radio"/>	<input type="radio"/>		
Strokes	<input type="radio"/>	<input type="radio"/>		
Other:				

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Surgical History:

	Yes	No	Occurrence Date (approximately)	Comments
Abdominal Aortic Aneurysm	<input type="radio"/>	<input type="radio"/>		
Appendectomy	<input type="radio"/>	<input type="radio"/>		
Back Surgery	<input type="radio"/>	<input type="radio"/>		
Bowel Surgery	<input type="radio"/>	<input type="radio"/>		
Brain Surgery	<input type="radio"/>	<input type="radio"/>		
Breast Lumpectomy	<input type="radio"/>	<input type="radio"/>		
Breast Mastectomy	<input type="radio"/>	<input type="radio"/>		
Cardiac Bypass	<input type="radio"/>	<input type="radio"/>		
Cardiac Catheterization	<input type="radio"/>	<input type="radio"/>		
C-Section	<input type="radio"/>	<input type="radio"/>		
Cosmetic Surgery	<input type="radio"/>	<input type="radio"/>		
ENT Surgery	<input type="radio"/>	<input type="radio"/>		
Eye Surgery	<input type="radio"/>	<input type="radio"/>		
Gallbladder Surgery	<input type="radio"/>	<input type="radio"/>		
Heart Surgery	<input type="radio"/>	<input type="radio"/>		
Hernia Repair	<input type="radio"/>	<input type="radio"/>		
Hip Surgery	<input type="radio"/>	<input type="radio"/>		
Hysterectomy	<input type="radio"/>	<input type="radio"/>		
Kidney/Bladder Surgery	<input type="radio"/>	<input type="radio"/>		
Knee Surgery	<input type="radio"/>	<input type="radio"/>		
Lung Surgery	<input type="radio"/>	<input type="radio"/>		
Moh's Surgery	<input type="radio"/>	<input type="radio"/>		
Prostate Surgery	<input type="radio"/>	<input type="radio"/>		
Shoulder Surgery	<input type="radio"/>	<input type="radio"/>		
Spleen Surgery	<input type="radio"/>	<input type="radio"/>		
Tonsillectomy	<input type="radio"/>	<input type="radio"/>		
Tubal Ligation	<input type="radio"/>	<input type="radio"/>		
Vasectomy	<input type="radio"/>	<input type="radio"/>		
Other (please specify):				

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Family History:

Relationship	Name	Status (Alive or Deceased)	History of Alcohol or Drug Problems	Allergies	Problems with Anesthesia	Arthritis	Blood Diseases	Cancer	Diabetes	Genetic	Gastrointestinal Problems	Genitourinary (GU)	Heart	Hypertension	Lipid Problems	Neurological	Psychiatric Problems	Stroke	Thyroid	Other (please specify)	
Mother																					
Father																					
Sister																					
Brother																					
Maternal Grandmother																					
Maternal Grandfather																					
Paternal Grandmother																					
Paternal Grandfather																					
Daughter																					
Son																					
Other (please specify)																					

Substance History:

Do you use tobacco?

- Current Every Day Smoker
 Current Some Day Smoker
 Never
 Former Smoker
 Passive

Type of Tobacco?

- Cigarettes
 Pipe
 Cigars

Quit Date _____ Packs per Day _____ Years _____

Smokeless Tobacco Use?

- Current User
 Never Used
 Former User

Type of Smokeless Tobacco?

- Snuff
 Chew

Are you ready to quit? Yes No

Do you use alcohol?

- Yes
 No
 Comment: _____

Drinks per week:

_____ Glasses of wine _____ Cans of beer _____ Shots of liquor

_____ Drinks containing 0.4 oz of alcohol

Do you use recreational drugs?

- Yes
 No
 Comment: _____

Use per Week: _____

Types? Cocaine Marijuana Methamphetamine Stimulants Heroin

Depressants Hallucinogens

UT Southwestern Medical Center

General Outpatient Clinic Review of Systems

Pt. Name: _____

Address: _____

City

State

Zip

MRN: _____

DOB: _____ SEX: _____

In general, are you currently experiencing any of the following on a regular basis?

YES	NO	YES	NO	YES	NO
Constitutional		Cardiovascular		Musculoskeletal	
<input type="radio"/>	<input type="radio"/> Fever	<input type="radio"/>	<input type="radio"/> Chest Pain	<input type="radio"/>	<input type="radio"/> Muscle pain
<input type="radio"/>	<input type="radio"/> Chills	<input type="radio"/>	<input type="radio"/> Palpitations	<input type="radio"/>	<input type="radio"/> Neck pain
<input type="radio"/>	<input type="radio"/> Weight loss	<input type="radio"/>	<input type="radio"/> Leg (or ankle) swelling	<input type="radio"/>	<input type="radio"/> Back pain
<input type="radio"/>	<input type="radio"/> Weight gain	<input type="radio"/>	<input type="radio"/> Severe shortness of breath which awakens you from sleep	<input type="radio"/>	<input type="radio"/> Joint pain
<input type="radio"/>	<input type="radio"/> Fatigue			<input type="radio"/>	<input type="radio"/> Falls
<input type="radio"/>	<input type="radio"/> Excessive sweating	<input type="radio"/>	<input type="radio"/> Difficulty breathing when lying flat	Allergy / Endocrinology	
<input type="radio"/>	<input type="radio"/> Night sweats	Respiratory		<input type="radio"/>	<input type="radio"/> Environmental allergies
<input type="radio"/>	<input type="radio"/> General weakness	<input type="radio"/>	<input type="radio"/> Cough	<input type="radio"/>	<input type="radio"/> Seasonal allergies
<input type="radio"/>	<input type="radio"/> Hot flashes	<input type="radio"/>	<input type="radio"/> Coughing up blood	<input type="radio"/>	<input type="radio"/> Excessive (frequent) thirst
Skin		<input type="radio"/>	<input type="radio"/> Coughing up sputum/mucus	<input type="radio"/>	<input type="radio"/> Heat intolerance
<input type="radio"/>	<input type="radio"/> Rash	<input type="radio"/>	<input type="radio"/> Shortness of breath	<input type="radio"/>	<input type="radio"/> Cold intolerance
<input type="radio"/>	<input type="radio"/> Itching	<input type="radio"/>	<input type="radio"/> Wheezing	<input type="radio"/>	<input type="radio"/> Easily bruise or bleed
<input type="radio"/>	<input type="radio"/> Change in mole(s)	<input type="radio"/>	<input type="radio"/> Noisy or high-pitched breathing	Neurological	
<input type="radio"/>	<input type="radio"/> Unusual hair loss	<input type="radio"/>	<input type="radio"/> Pain with breathing	<input type="radio"/>	<input type="radio"/> Dizziness
<input type="radio"/>	<input type="radio"/> Breast concerns	Gastrointestinal		<input type="radio"/>	<input type="radio"/> Tremors
Head		<input type="radio"/>	<input type="radio"/> Heartburn	<input type="radio"/>	<input type="radio"/> Sensory change (<i>Numbness, tingling</i>)
<input type="radio"/>	<input type="radio"/> Headaches	<input type="radio"/>	<input type="radio"/> Change in appetite	<input type="radio"/>	<input type="radio"/> Speech change
<input type="radio"/>	<input type="radio"/> Difficulty hearing	<input type="radio"/>	<input type="radio"/> Nausea	<input type="radio"/>	<input type="radio"/> Weakness in a specific location (<i>one arm, leg, or other area</i>)
<input type="radio"/>	<input type="radio"/> Ringing in ears	<input type="radio"/>	<input type="radio"/> Vomiting	<input type="radio"/>	<input type="radio"/> Seizures
<input type="radio"/>	<input type="radio"/> Ear discharge	<input type="radio"/>	<input type="radio"/> Abdominal pain	<input type="radio"/>	<input type="radio"/> Loss of consciousness
<input type="radio"/>	<input type="radio"/> Ear pain	<input type="radio"/>	<input type="radio"/> Diarrhea	Mental and emotional	
<input type="radio"/>	<input type="radio"/> Nosebleeds	<input type="radio"/>	<input type="radio"/> Constipation	<input type="radio"/>	<input type="radio"/> Substance abuse
<input type="radio"/>	<input type="radio"/> Nasal congestion	<input type="radio"/>	<input type="radio"/> Blood in stool	<input type="radio"/>	<input type="radio"/> Hallucinations
<input type="radio"/>	<input type="radio"/> Loss of smell	<input type="radio"/>	<input type="radio"/> Black stool	<input type="radio"/>	<input type="radio"/> Feeling nervous or anxious
<input type="radio"/>	<input type="radio"/> Snoring	<input type="radio"/>	<input type="radio"/> Incontinence of stool	<input type="radio"/>	<input type="radio"/> Insomnia
<input type="radio"/>	<input type="radio"/> Difficulty swallowing	Genitourinary / Urogenital		<input type="radio"/>	<input type="radio"/> Memory lapses or loss
<input type="radio"/>	<input type="radio"/> Sore throat	<input type="radio"/>	<input type="radio"/> Urgent/sudden need to urinate	<input type="radio"/>	<input type="radio"/> Depression
<input type="radio"/>	<input type="radio"/> Mouth sores	<input type="radio"/>	<input type="radio"/> Blood in urine	OTHER CONCERNS	
Eyes		<input type="radio"/>	<input type="radio"/> Painful or burning urination		
<input type="radio"/>	<input type="radio"/> Blurred vision	<input type="radio"/>	<input type="radio"/> Frequent need to urinate		
<input type="radio"/>	<input type="radio"/> Double vision	<input type="radio"/>	<input type="radio"/> Need to get up at night to urinate		
<input type="radio"/>	<input type="radio"/> Light sensitivity	<input type="radio"/>	<input type="radio"/> Loss of bladder control		
<input type="radio"/>	<input type="radio"/> Eye pain	<input type="radio"/>	<input type="radio"/> Sexual difficulties		
<input type="radio"/>	<input type="radio"/> Eye discharge	<input type="radio"/>	<input type="radio"/> WOMEN: Vaginal discharge		
<input type="radio"/>	<input type="radio"/> Redness	<input type="radio"/>	<input type="radio"/> WOMEN: Vaginal concerns		
		<input type="radio"/>	<input type="radio"/> MEN: Penile discharge		

