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:**		

PERSONAL HEALTH HISTORY

Reason for visit:

Chief complaint:

Duration of complaint:

Trend of symptoms: ☐ Worsening ☐ Improving ☐ Constant ☐ Waxes and wanes ☐ No change
☐ Episodic ☐ Other:

Hospitalizations

Year	Reason	Hospital

Year	Reason	Hospital

PRIOR MEDICAL CONDITIONS: ANSWER ONLY ONES THAT APPLY

Cancer:

☐	Breast	☐	Ovarian	☐	Lung
☐	Throat	☐	Bone	☐	Pancreatic
☐	Prostate	☐	Skin	☐	Radiation
☐	Chemotherapy	☐	Brain	☐	Colon

Prior Medical Conditions (cont): Answer only ones that apply

Heart Disease:

☐	Heart Attack	☐	Heart Failure	☐	Hypertension/High Blood Pressure
☐	Hyperlipidema/High Cholesterol	☐		☐	

ENT:

☐	ENT Problems	☐	Eye Disease	☐	Hearing Impaired

Skin:

☐	Skin Disease	☐	Abnormal Moles	☐	

Musculoskeletal:

☐	Arthritis	☐	Osteoporosis	☐	Rheumatoid Arthritis
☐	Chronic Back Pain	☐	Fibromyalgia	☐	Degenerative Bone Disease
☐	Growth/Development Disorder	☐		☐	

Endocrine:

☐	Autoimmune Disorder	☐	Diabetes type _____	☐	Thyroid Disease
☐	Kidney Disease	☐		☐	

Respiratory:

☐	TB	☐	Asthma	☐	Chronic Lung Disease/COPD
☐	Pneumonia	☐	Bronchitis	☐	

Neurological:

☐	Stroke	☐	Epilepsy/Seizures	☐	Chronic Headaches

Psych/Social:

☐	Anxiety	☐	Depression	☐	Bipolar Illness
☐	Suicide Attempt	☐	Post-traumatic Stress Disorder	☐	

Other:

☐	Anemia	☐	Bleeding Disease	☐	Ability to sleep
☐	Energy level	☐	Other pain/discomfort:	☐	Excessive Weight Gain
☐	Decreased Libido	☐	Erectile Difficulties	☐	
☐		☐		☐	

Have you ever had a blood transfusion?	☐	Yes	☐	No
What Year:				

Past Surgeries: Answer only ones that apply.

Cardiac Surgery:

☐	Cardiovascular Surgery	☐	Valvular Surgery	☐	Peripheral Surgery

ENT Surgery:

☐	ENT Surgery	☐	Cataract Surgery	☐	Sinus Surgery
☐	Septoplasty Surgery	☐	Tonsillectomy Surgery	☐	

Musculoskeletal Surgery:

☐	Orthopedic Surgery	☐	Cervical Laminectomy	☐	Lumbar Laminectomy
☐	Back Surgery	☐	Shoulder Surgery	☐	Foot Surgery
☐	Knee Surgery	☐		☐	

Respiratory:

☐	Lung (Pneumonectomy)	☐	Wedge Resection, removal of wedge.	☐	Lobectomy, removal of one lobe.

GU Surgery:

☐	Vasectomy	☐	Renal Surgery	☐	Prostate Surgery

GI Surgery:

☐	Hemorrhoidectomy	☐	Ulcer Surgery	☐	Appendectomy (Appendix)
☐	Colectomy (Colon)	☐	Cholecystectomy (gall bladder)	☐	Hernia Surgery

GYN Surgery:

☐	Tubal Ligation	☐	Uterine Surgery	☐	Lumpectomy
☐	Mastectomy	☐	Breast Reduction	☐	Hysterectomy
☐	Ovary Removal	☐		☐	

Other:

☐	Neurological Surgery	☐	Thyroid Surgery	☐	Hematologic-Oncologic

Diagnostic Test done with in the last 6 months:

☐	Mammogram	☐	Computed Tomography (CT Scan)	☐	Bone Density
☐	Lung Scanning (V/Q scan)	☐	Chest X-ray	☐	Magnetic Resonance Imaging (MRI)
☐	Position Emission Tomography (PET)	☐	Pulmonary Angiography	☐	

Medications

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

Allergies to medications	
Name the Drug	Reaction You Had
Name of Pharmacy	
Phone Number of Pharmacy	

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., between 2 to 4 times a week for 30 min.)							
	☐ Regular vigorous exercise (i.e., 4 to 6 times a week for 60 minutes)							
Diet	Are you dieting?				☐ Yes	☐ No		
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No		
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		
Tobacco	Do you use tobacco?				☐ Yes	☐ No		
	☐ Cigarettes # packs a 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
	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 have an Advance Directive or Living Will?		☐	Yes	☐	No
	Would you like information on the preparation of these?		☐	Yes	☐	No
	Do you live alone?		☐	Yes	☐	No
	Immunizations:					
	Influenza (**FLU**)	Date:	☐	Yes	☐	No
	Pneumococcal	Date:	☐	Yes	☐	No
	Purified Protein Derivative, **PPD** (TB Test)	Date:	☐	Yes	☐	No

Family Health History

FATHER	**MOTHER**
☐ Deceased Cause of Death: ____________________ ☐ Alive	☐ Deceased Cause of Death: __________________ ☐ Alive
Age:	Age:

Please list significant health problems:

FATHER	MOTHER	GRAND FATHER (S)	GRAND MOTHER (S)	BROTHER (S)	SISTER (S)
☐ Cancer ☐ Heart Disease ☐ Diabetes ☐ Respiratory ☐ Psychiatric ☐ Anemia ☐ Arthritis ☐ Thyroid ☐ Other	☐ Cancer ☐ Heart Disease ☐ Diabetes ☐ Respiratory ☐ Psychiatric ☐ Anemia ☐ Arthritis ☐ Thyroid ☐ Other	☐ Cancer ☐ Heart Disease ☐ Diabetes ☐ Respiratory ☐ Psychiatric ☐ Anemia ☐ Arthritis ☐ Thyroid ☐ Other	☐ Cancer ☐ Heart Disease ☐ Diabetes ☐ Respiratory ☐ Psychiatric ☐ Anemia ☐ Arthritis ☐ Thyroid ☐ Other	☐ Cancer ☐ Heart Disease ☐ Diabetes ☐ Respiratory ☐ Psychiatric ☐ Anemia ☐ Arthritis ☐ Thyroid ☐ Other	☐ Cancer ☐ Heart Disease ☐ Diabetes ☐ Respiratory ☐ Psychiatric ☐ Anemia ☐ Arthritis ☐ Thyroid ☐ Other
List condition:	List condition:	List condition:	List condition:	List condition:	List condition:

NH0670

ADDRESSOGRAPH

NORTHSIDE HOSPITAL

SLEEP DISORDERS CENTER

AFFIX PATIENT LABELS OVER THIS BOX

BAR CODE MUST FALL BETWEEN THESE LINES

Patient Name: _____

Gender (circle one): Male Female Age: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to decide how you would react to these situations. Use the following scale to choose the most appropriate number for each one.

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	**CHANCE OF DOZING** (circle one)			
Sitting and reading.	0	1	2	3
Watching TV.	0	1	2	3
Sitting, inactive in a public place (e.g., theater or meeting).	0	1	2	3
As a passenger in a car for an hour without a break.	0	1	2	3
Lying down to rest in the afternoon when circumstances permit.	0	1	2	3
Sitting and talking to someone.	0	1	2	3
Sitting quietly after lunch without alcohol.	0	1	2	3
In a car, while stopped for a few minutes in traffic.	0	1	2	3

TOTAL SCORE: _____ **AVERAGE AMOUNT OF SLEEP PER NIGHT:** _____

SIGN HERE: Completed by: _____ Date/Time: _____

Reviewed by: _____ Date/Time: _____

EPWORTH SLEEPINESS SCALE