Original Date:
Dates Revised:

DEBORAH BEUTLER, M.D.

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

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Shingles
	☐ Influenza	☐

List any medical problems that other doctors have diagnosed (please circle)

High Blood pressure	Lung disease	cancer	stomach ulcer
Diabetes	kidney problem	broken bone	Dementia
Heart disease	liver disease	arthritis	chronic pain
High cholesterol	stroke	thyroid disease	

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)			☐ moderate exercise	
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			☐ regular exercise	
	Do you drink alcohol? ☐ Yes ☐ No		Do you use tobacco? ☐ Yes ☐ No		
Tobacco					
		☐ 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

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			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**

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
Any hot flashes or sweating at night?	☐ Yes	☐ No
Date of last pap and rectal exam?		
MEN ONLY		
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.

☐ Neurology: Headaches, Dizziness, Confusion	☐ Gastroenterology: Acid Reflex, Bloating, Abd. Pain, Abd. Swelling	**Recent changes in:** (Please Explain)
☐ Muscle: Cramps, Stuffiness, Swelling	☐ Respiratory: Dry mouth, sputum, Persistent cough	☐ *Appetite:*
☐ Skin rash, mole, Lumps	☐ Chest/Heart: pain, palpitation	☐ *Weight:*
☐ Head/Neck pain ,swelling,	☐ Back/joint pain, stiffness, Swelling	☐ *Energy level:*
☐ Ears pain, discharge, ringing	☐ Intestinal constipation, diarrhea, Change in stool	☐ *Ability to sleep:*
☐ Nose: congestion, Bleeding, Loss of Smell	☐ Urinary Frequent, Uncontrolled, Burning Sensation	☐ *Physiological:*
☐ Throat: pain, swelling, Discharge	☐ Brain: Weakness, Numbness, Memory Loss	☐ *Other pain/discomfort:*
☐ Lungs: difficulty breathing, wheezing	☐ Circulation Leg pain, Numb limbs, Varicose veins	