

**CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE - PAST MEDICAL HISTORY**

**Leesburg/Sterling Family Practice**

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

**ALLERGIES**

None

*(List any allergies to medicines or other substances)*

**SURGERY/HOSPITALIZATION**

DATE REASON None

**ILLNESSES**

None

*(List any chronic or recurrent illnesses - Date of onset)*

**ACCIDENTS / INJURIES**

*(Please list)*

None

DATE

**LIST ALL MEDICATIONS YOU TAKE REGULARLY  
(PRESCRIPTION and NON-PRESCRIPTION)**

Medicine Dose None

CHECK ANY THAT YOU HAVE HAD OR NOW HAVE:

- |   |   |
|---|---|
| <input type="checkbox"/> Abnormal Pap Smear               | <input type="checkbox"/> Herpes                                 |
| <input type="checkbox"/> AIDS or HIV Disease              | <input type="checkbox"/> High Blood Pressure                    |
| <input type="checkbox"/> Alcohol Overuse or Abuse         | <input type="checkbox"/> Hodgkins Disease, Lymphoma or Leukemia |
| <input type="checkbox"/> Allergies or Hay Fever           | <input type="checkbox"/> Irritable Bowel Syndrome               |
| <input type="checkbox"/> Anemia (i.e. - low iron)         | <input type="checkbox"/> Kidney Disease or Nephritis            |
| <input type="checkbox"/> Anxiety or Panic Attacks         | <input type="checkbox"/> Kidney Stones                          |
| <input type="checkbox"/> Arthritis or Gout                | <input type="checkbox"/> Liver Problems                         |
| <input type="checkbox"/> Asthma                           | <input type="checkbox"/> Lung Problems                          |
| <input type="checkbox"/> Back Problems                    | <input type="checkbox"/> Lupus                                  |
| <input type="checkbox"/> Bladder Infection                | <input type="checkbox"/> Malaria                                |
| <input type="checkbox"/> Blood Clots or Bleeding Prob.    | <input type="checkbox"/> Meningitis                             |
| <input type="checkbox"/> Blood Transfusion                | <input type="checkbox"/> Migraine Headache                      |
| <input type="checkbox"/> Boils or Cysts - Recurrent       | <input type="checkbox"/> Muscle Disease or Weakness             |
| <input type="checkbox"/> Bone or Joint Disease            | <input type="checkbox"/> Nervous Breakdown                      |
| <input type="checkbox"/> Bowel or Colon Disease           | <input type="checkbox"/> Pancreatitis                           |
| <input type="checkbox"/> Broken or Cracked Bones          | <input type="checkbox"/> Phlebitis                              |
| <input type="checkbox"/> Breast Lumps                     | <input type="checkbox"/> Pleurisy                               |
| <input type="checkbox"/> Bronchitis - Recurrent           | <input type="checkbox"/> Pneumonia                              |
| <input type="checkbox"/> Bursitis or Tendonitis           | <input type="checkbox"/> Polio                                  |
| <input type="checkbox"/> Cancer                           | <input type="checkbox"/> Rheumatoid Arthritis                   |
| <input type="checkbox"/> Cholesterol - Elevated           | <input type="checkbox"/> Rheumatic Fever                        |
| <input type="checkbox"/> Colitis                          | <input type="checkbox"/> Seizures, Convulsions, or Epilepsy     |
| <input type="checkbox"/> Concussion or Head Injury        | <input type="checkbox"/> Sexually Transmitted Disease           |
| <input type="checkbox"/> Depression or Suicide            | <input type="checkbox"/> Sickle Cell Disease or Trait           |
| <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Skin Disease - Chronic                 |
| <input type="checkbox"/> Drug Overuse or Abuse            | <input type="checkbox"/> Skin Infections - Recurrent            |
| <input type="checkbox"/> Emphysema                        | <input type="checkbox"/> Sleep Difficulties or Disorders        |
| <input type="checkbox"/> Excessive Stress                 | <input type="checkbox"/> Sprains or Dislocations - Severe       |
| <input type="checkbox"/> Gallbladder Disease or Gallstone | <input type="checkbox"/> Stroke or Brain Attack                 |
| <input type="checkbox"/> Glaucoma                         | <input type="checkbox"/> Thyroid Disease                        |
| <input type="checkbox"/> Gonorrhea, Syphilis or Chlamydia | <input type="checkbox"/> Tuberculosis (TB) or postive test      |
| <input type="checkbox"/> Headaches - Severe               | <input type="checkbox"/> Ulcer Disease or Gastritis             |
| <input type="checkbox"/> Hearing Problem                  | <input type="checkbox"/> Varicose Veins                         |
| <input type="checkbox"/> Heart Attack                     | <input type="checkbox"/> Venereal Disease                       |
| <input type="checkbox"/> Heart Murmur or Heart Disease    | <input type="checkbox"/> Vision Problem                         |
| <input type="checkbox"/> Hepatitis or Cirrhosis           | <input type="checkbox"/> Yellow Jaundice                        |
| <input type="checkbox"/> Herniated or Ruptured Disc       | <input type="checkbox"/> Other _____                            |

**IMMUNIZATION HISTORY:**

HAVE YOU HAD:		DATE OF LAST
Chickenpox or Shot	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Hepatitis B Series or Shots	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Influenza Shot	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Pneumonia Shot	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Rubella Shot or Blood Test	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Tetanus Shot	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____