

**SURGICAL SPECIALISTS OF WAYNE COUNTY
Vein Specialty Center, dba**

HEALTH HISTORY QUESTIONNAIRE

**ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL
AND WILL BECOME PART OF YOUR MEDICAL RECORD.**

Today's date:

Name <small>(Last, First, M.I.):</small>	<input type="checkbox"/> M	<input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Previous or referring doctor:		Date of last physical exam:	

PERSONAL HEALTH HISTORY

Childhood illness:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio					
Immunizations and dates:	<input type="checkbox"/> Tetanus			<input type="checkbox"/> Pneumonia		
	<input type="checkbox"/> Hepatitis			<input type="checkbox"/> Chickenpox		
	<input type="checkbox"/> Influenza			<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>		

List any major medical problems that other doctors have diagnosed

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Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
Mother				<input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> F		Grandfather <i>Maternal</i>		
<input type="checkbox"/> M		Grandmother <i>Paternal</i>			
<input type="checkbox"/> F		Grandfather <i>Paternal</i>			

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies Number of live births		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times		
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

