

HISTORY QUESTIONNAIRE - Adult

Patient's Name

Patient's Date of Birth

The attached questionnaire is important to supply us and is designed to provide important information in a consistent manner. We need this form filled out even if you supply some other narrative of the history. Much of this information is regarding early childhood development, milestones, and family relationships & history. Many have found looking through your "baby book" or other records you may have will frequently generate answers. In addition, it is nice to have a recent photograph.

To take full advantage of the time you have with your physician in your appointment:

- please answer as many of the questions as possible,
- answer as fully as possible, and
- **return to us as soon as possible but at least 2 weeks prior** to your scheduled appointment.

We are honored that you have allowed us to participate in your care.

What do you hope to accomplish with this appointment?

What are the most important questions that need to be addressed during your appointment?

PREGNANCY: Please answer to the best of your ability. If unknown, please indicate UKN.

1. How old was your mother when she became pregnant with you? _____

2. What number pregnancy was this pregnancy for your mother? _____

3. Was prenatal care provided? yes no
If so, do you at what point in pregnancy prenatal care was initiated? _____

4. Was an ultrasound done as a part of the prenatal care? yes no

5. How many ultrasounds were done? _____
When during the pregnancy were the ultrasounds completed?

- | | |
|-----------|-----------|
| #1. _____ | #4. _____ |
| #2. _____ | #5. _____ |
| #3. _____ | #6. _____ |

(Please list on back page any additional ultrasound studies completed.)

Where was each ultrasound completed? (i.e. OB's office, hospital, etc.)

- | | |
|-----------|-----------|
| #1. _____ | #4. _____ |
| #2. _____ | #5. _____ |
| #3. _____ | #6. _____ |

(Please list on back page any additional ultrasound studies completed.)

6. Were any of the ultrasounds abnormal? yes no
If **yes**, explain in the space below:

7. Were other special studies done during this pregnancy? yes no
Include alpha-fetoprotein, amniocentesis, glucose tolerance test, and other study results here. If **yes**, please explain in the space below:

8. List all over-the-counter and prescription medications, vitamins, health preparations, cigarettes, etc. used during this pregnancy (include name/brand, amount, and when taken during the pregnancy).

9. The pregnancy was complicated by (answer yes or no):

	<u>Yes</u>	<u>No</u>	<u>Time in Pregnancy</u>
Bleeding/spotting	_____	_____	_____
Cold or Flu-like illness	_____	_____	_____
Bladder Infection	_____	_____	_____
Fever	_____	_____	_____
Yeast Infection	_____	_____	_____
Other Vaginal Infection	_____	_____	_____
Skin Rash	_____	_____	_____
Dehydration from Vomiting	_____	_____	_____
Abnormal growth of the baby	_____	_____	_____
Premature labor	_____	_____	_____
High blood pressure	_____	_____	_____
Blood sugar problems	_____	_____	_____
Exposure to x-rays or chemicals	_____	_____	_____
Other	_____	_____	_____

10. Would your mother describe your activity in the womb during the pregnancy as (check only one):

Very active moderately active
 Occasionally active rarely moved

11. How much weight did your mother gain during pregnancy? _____

DELIVERY:

Due Date: _____ Birth date: _____ Birth Hospital: _____

1. Born at full-term? yes no
If not, how premature was the birth? _____

2. How long was your mother's labor? _____ hours

3. What type of delivery ? (Check one):

a) _____ Vaginal _____ C-section _____ Repeat C-section because of previous delivery this way

b) _____ Head first _____ Shoulder(s) first _____ Bottom first _____ Feet first

BIRTH:

1. Weight? _____ Length? _____ Chest size? _____ Head size? _____

2. Do you know of any problems at birth? If so, please describe in the space below
(You may use the attached blank sheet)

3. Babies are given special scores at birth called Apgar scores based on the baby's color, breathing, heartbeat, muscle tone, and cry.

If you have records of the Apgar scores, please record them here:

_____ at 1 minute _____ at 5 minutes

4. After birth, how were you fed? (check one)

_____ Breast _____ Bottle _____ Other

5. You were discharged from the hospital to home at _____ (days/weeks) of age.

FIRST YEAR:

1. Did you have any complications during the first month of life? yes no
If **yes**, please explain in the space below:

2. Were there any complications in the first year of life?

DEVELOPMENTAL MILESTONES HISTORY:

1. Please record your age beside the milestones you met as a child and circle months or years (as best you can):

Rolled over ____ months/years

Sat alone ____ months/years

Crawled ____ months/years

First word ____ months/years

Walked holding onto furniture ____ months/years

Walked alone ____ months/years

2. Did you ever receive any special services (OT, PT, speech)? If **yes**, list type and number of services (e.g. PT 3 times a week for one hour) each session.

4. Were you ever enrolled in a special education program? yes no

If **yes**, at what age? _____

(Please bring a copy of any developmental evaluation reports)

What level of education did you complete? (circle one)

Grade school

High School

Technical School

College ____ #yrs

5. Do you feel that you have lost ability to perform skills or life activities that you previously had? yes no

If **yes**, please explain in the space below.

6. Do you have vision problems? yes no

If yes, please explain in the space below.

7. Do you have hearing problems? yes no

If yes, please explain in the space below.

TOP PROBLEMS/DIAGNOSES:

- (1) _____
- (2) _____
- (3) _____
- (4) _____
- (5) _____

GENETIC TESTING TO DATE: (List all genetic testing and which lab performed them)

HOSPITALIZATIONS: (List all hospital admissions—name of hospital, length of stay and reason for admission) *Please use back of this sheet if additional space is needed.*

SURGERIES: _____

PROCEDURES: _____

Date of last MRI: _____ **Result of MRI:** _____

MEDICATIONS: What medications/supplements, if any, are you currently taking?

Please use back of this sheet if additional space is needed.

Name of Medication	Dosage	Time
--------------------	--------	------

REVIEW OF SYSTEMS: circle or underline those issues you are experiencing

Constitutional: fatigue, fever, weight loss, weight gain, altered taste/smell, unable to sleep, excessive sleepiness, abnormal growth, lost interest in activities, Birthmark

Cardiovascular: sensation of chest pain/pressure/squeezing, shortness of breath on exertion, lower extremity swelling, chest pressure, fainting, heart failure, high blood pressure, shortness of breath, coronary disease, heat/cold intolerance, fainting

Endocrine: diabetes, thyroid disease, growth disorders, sexual dysfunction, excessive thirst or hunger, frequent urination, nausea

Eyes: double vision, blurred vision, floaters, glaucoma, cataracts, loss of peripheral vision, macular degeneration, drooping eye lids

Gastrointestinal: vomiting, diarrhea, reflux, constipation, abdominal pain, gastritis, hepatitis, hiatal hernia, rectal bleeding, ulcer, indigestion, nausea

Genitourinary: urine incontinence, stool incontinence, sexual dysfunction, constipation

Heme-Lymph: lymph node enlargement or tenderness, blood disorder, diabetes, sickle cell disease, thyroid disease, HIV, AIDS

HENT: loss of hearing, balance problems, nasal congestion, postnasal drip, neck pain, sore throat, tinnitus, allergies/hayfever, trouble breathing through nose, sinus disease, mouth sores, trouble swallowing, snoring

Respiratory: cough, bronchitis, emphysema, pneumonia, tuberculosis, asthma

Integument: rash, breast disease, melanoma, basal cell cancer, abnormal scars, easy bruising

Immunologic: frequent illnesses, recurrent infections

Musculoskeletal: joint pain, joint swelling, back pain, neck pain, hypermobile joints, muscle weakness, loss of muscle mass, lack of endurance

Neurologic: speech difficulties, incoordination, aggressive, trouble learning, trouble hearing, memory difficulties, seizures, tremors, head injuries, dizziness, hallucination, personality change, weakness, pain, facial numbness/tingling, numbness-arms, numbness-legs, nausea, stiffness, difficulty chewing, stares off into space, choking, difficulty tasting, drooling, trouble walking, vertigo, difficulty concentrating, fainting or passing out, difficulty sleeping, swallowing problems, trouble with smell, spells/fits, confusion, hostile/angry

Psychiatric: anxiety, depression, hallucinations, trouble concentrating, schizophrenia, in trouble at school, shy, panic attacks

ALLERGIES: Do you have any allergies? yes no

If so, to what medications? _____

Other allergies: _____

PHYSICIANS TO RECEIVE A COPY OF OUR LETTER (s):

Please include fax number as this is how we provide copies.

Name of Physician	Practice/Website	Phone	Fax (important)
-------------------	------------------	-------	-----------------

(Use another sheet or the back of this page if required)

FAMILY HISTORY

Please complete all sections on this form. If there is not sufficient space provided, use the back of the pages, indicating the section letter being supplemented.

Section A - Information about your brothers and sisters.

Please list these – include any miscarriages that your mother may have had. Differentiate between sisters and brothers who have the same 2 parents as you and those who share only 1 parent. Indicate the parent in common. If any sisters or brothers have had children, include this information and note any problems these children may or may have had.

Name, birth date, sex, living or age at death, medical problems, if any

- (1) _____
- (2) _____
- (3) _____
- (4) _____
- (5) _____

Section B - Information about your children

Please include in list any miscarriages that you/spouse may have had. Differentiate between children who have different mothers. If any children have had children, include this information and note any problems these children may or may have had.

Name, birth date, sex, living or age at death, medical problems, if any

- (1) _____
- (2) _____
- (3) _____
- (4) _____
- (5) _____

SECTION C – Information about the your parents and aunts and uncles (parents' brothers and sisters)

In this section, list the patient's "Father" and the "Mother", their sisters and brothers, their children and any medical problems in these individuals.

(Your) Father & His Brothers & Sisters

(Your) Mother & Her Brothers & Sisters

Your Father: _____
 Birth Date: _____
 Medical problems, if known: _____
 If deceased, age at time of death: _____
 Cause of death, if known: _____
 Number of children: _____

Your Mother (maiden): _____
 Birth date: _____
 Medical problems, if known: _____
 If deceased, age at time of death: _____
 Cause of death, if known: _____
 Number of children: _____

Name: _____
 Age (if living): _____
 Medical problems, if known: _____
 If deceased, age at time of death: _____
 Cause of death, if known: _____
 Number of children: _____

Name (maiden): _____
 Age (if living): _____
 Medical problems, if known: _____
 If deceased, age at time of death: _____
 Cause of death, if known: _____
 Number of children: _____

Name: _____
 Age (if living): _____
 Medical problems, if known: _____
 If deceased, age at time of death: _____
 Cause of death, if known: _____
 Number of children: _____

Name (maiden): _____
 Age (if living): _____
 Medical problems, if known: _____
 If deceased, age at time of death: _____
 Cause of death, if known: _____
 Number of children: _____

SECTION D – Information about your Grandparents

In these next 2 sections, list the parents of the "Father" and the "Mother" from Section C (grandparents to you), and each grandparent's sisters and brothers, their children and any medical problems in these individuals. Use additional sheets of paper if necessary.

Father's Family

(His Parents, Aunts, Uncles, Cousins)

Father's Father & His Brothers/Sisters

Father's Father: _____

Age (if living): _____

Medical problems, if known: _____

If deceased, age at time of death: _____

Cause of death, if known: _____

Number of children: _____

Name: _____

Age (if living): _____

Medical problems, if known: _____

If deceased, age at time of death: _____

Cause of death, if known: _____

Number of children: _____

Name: _____

Age (if living): _____

Medical problems, if known: _____

If deceased, age at time of death: _____

Cause of death, if known: _____

Number of children: _____

Name: _____

Age (if living): _____

Medical problems, if known: _____

If deceased, age at time of death: _____

Cause of death, if known: _____

Number of children: _____

Name: _____

Age (if living): _____

Medical problems, if known: _____

If deceased, age at time of death: _____

Cause of death, if known: _____

Number of children: _____

Father's Mother & Her Brothers/Sisters

Father's Mother (maiden): _____

Age (if living): _____

Medical problems, if known: _____

If deceased, age at time of death: _____

Cause of death, if known: _____

Number of children: _____

Name (maiden): _____

Age (if living): _____

Medical problems, if known: _____

If deceased, age at time of death: _____

Cause of death, if known: _____

Number of children: _____

Name (maiden): _____

Age (if living): _____

Medical problems, if known: _____

If deceased, age at time of death: _____

Cause of death, if known: _____

Number of children: _____

Name (maiden): _____

Age (if living): _____

Medical problems, if known: _____

If deceased, age at time of death: _____

Cause of death, if known: _____

Number of children: _____

Name (maiden): _____

Age (if living): _____

Medical problems, if known: _____

If deceased, age at time of death: _____

Cause of death, if known: _____

Number of children: _____

Mother's Family
(Her Parents, Aunts, Uncles, Cousins)

Mother's Father & His Brothers/Sisters

Mother's Father: _____
Age (if living): _____
Medical problems, if known: _____
If deceased, age at time of death: _____
Cause of death, if known: _____
Number of children: _____

Name: _____
Age (if living): _____
Medical problems, if known: _____
If deceased, age at time of death: _____
Cause of death, if known: _____
Number of children: _____

Name: _____
Age (if living): _____
Medical problems, if known: _____
If deceased, age at time of death: _____
Cause of death, if known: _____
Number of children: _____

Name: _____
Age (if living): _____
Medical problems, if known: _____
If deceased, age at time of death: _____
Cause of death, if known: _____
Number of children: _____

Name: _____
Age (if living): _____
Medical problems, if known: _____
If deceased, age at time of death: _____
Cause of death, if known: _____
Number of children: _____

Mother's Mother & Her Brothers/Sisters

Mother's Mother (maiden): _____
Age (if living): _____
Medical problems, if known: _____
If deceased, age at time of death: _____
Cause of death, if known: _____
Number of children: _____

Name (maiden): _____
Age (if living): _____
Medical problems, if known: _____
If deceased, age at time of death: _____
Cause of death, if known: _____
Number of children: _____

Name (maiden): _____
Age (if living): _____
Medical problems, if known: _____
If deceased, age at time of death: _____
Cause of death, if known: _____
Number of children: _____

Name (maiden): _____
Age (if living): _____
Medical problems, if known: _____
If deceased, age at time of death: _____
Cause of death, if known: _____
Number of children: _____

Name (maiden): _____
Age (if living): _____
Medical problems, if known: _____
If deceased, age at time of death: _____
Cause of death, if known: _____
Number of children: _____

GENERAL FAMILY INFORMATION:

1. What is the ethnicity of your parents' families (i.e. are you Scottish, Irish, German, Polish, Mayan, Vietnamese, Spanish, Portuguese, African American, etc.)?

Your mother's family: _____

Your father's family: _____

2. As far back as you can trace your ancestors; do your parents' have any common relatives? (i.e. do you share a grandparent, great grandparent, etc) yes no

GENERAL NOTES: