# MID-SUFFOLK MEDICAL CARE P.C

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Diplomate, American Board of Internal Medicine

**INDEPENDENT PRACTICE --> WORKING ONLY FOR YOU.**

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## COMPREHENSIVE HEALTH HISTORY QUESTIONNAIRE

**Name:** _____ **Date:** _____

**Address:** _____ **Date of Birth:** _____

_____ **Marital Status:** ☐ S ☐ M ☐ D ☐ W

**Phone (Home):** _____ **Business:** _____ **Sex:** ☐ M ☐ F

## PAST HEALTH HISTORY

**YOUR PAST HISTORY OF MEDICAL PROBLEMS, ILLNESSES, INJURIES, SURGERIES AND HOSPITALIZATIONS**

Please mark with an (X) any of the following illnesses and medical problems you ever had and indicate approximately the year each started.

**PLEASE INCLUDE DETAILS IN SPACE PROVIDED BELOW**

| Illness | (x) | (Year) |
|---|---|---|
| Galucoma | | |
| Cataracts | | |
| Other eye problems | | |
| Ear trouble | | |
| Deafnes | | |
| Bronchitis | | |
| Emphysema | | |
| Pneumonia | | |
| Hay Fever | | |
| Asthma | | |
| Tuberculosis | | |
| Other lung problems | | |
| High blood pressure | | |
| Heart Attack/Angina | | |
| Alteriosclerosis | | |
| Pacemaker | | |
| Heart Murmur | | |
| Other Heart Condition | | |
| High Cholestrol | | |
| Rheumatic Fever | | |
| Irregular Heartbeat | | |
| Stomach/duodenal ulcer | | |

| Illness | (x) | (Year) |
|---|---|---|
| Diverticulosis | | |
| Hiatal Hernia | | |
| Other eye problems | | |
| Colitis | | |
| Acid Reflux | | |
| Other bowel problem | | |
| Hepatitis | | |
| Liver trouble | | |
| Gallbladder trouble | | |
| Hernia | | |
| Hemorrhoids | | |
| Kidney Stone | | |
| Kidney/Bladder Disease | | |
| Prostate Problem | | |
| Psychiatric Condition | | |
| Headaches | | |
| Head Injury | | |
| Strokes | | |
| Convulsions, seizures | | |
| Arthritis | | |
| Chronic Back Pain | | |
| Gout | | |

| Illness | (x) | (Year) |
|---|---|---|
| Multiple Sclerosis | | |
| Depression/Anxiety | | |
| Skin Conditions | | |
| Cancer or Tumor | | |
| Anemia | | |
| Bleeding Tendency | | |
| Blood Transfusion | | |
| Thyroid Trouble | | |
| Diabetes | | |
| Alcoholism | | |
| Osteoporosis | | |
| Chicken Pox | | |
| Mononucleosis | | |
| Venereal Disease | | |
| Genital Herpes | | |
| Gynecologicals / Obstetrical Problems | | |
| Breast Problems | | |
| Phlebitis/Varicose Veins | | |
| AIDS | | |
| Medical Disorder Not Listed | | |

_____

_____

**PLEASE LIST ALL TIMES YOU HAVE BEEN HOSPITALIZED, OPERATED ON, OR SERIOUSLY INJURED.**

| Year | Operation, Illness, Injury |
|---|---|
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