Clear All

CONFIDENTIAL HEALTH HISTORY QUESTIONNARIE - PAST MEDICAL HISTORY

ClinTECH LLC - Clinical Research Site

Name: _____ Date of Birth: _____ Age: _____ Date: _____

ALLERGIES

(list any allergies to medicines or other substances) ☐ None

SURGERY/HOSPITALIZATION

Date | Reason ☐ None

MEDICAL PROBLEMS

List any chronic or recurrent medical problems - Date of onset

☐ None

List All Medication You Take Regularly (Prescription and Non-Prescription)

Medicine | Dose ☐ None

CHECK ANY THAT YOU HAVE HAD OR NOW HAVE:

Past/Current		Past/Current	
☐	Abnormal Electrocardiogram	☐	Heart Attack
☐	Abnormal Pap Smear	☐	Heart Murmur or Heart Disease
☐	AIDS or HIV	☐	Hepatitis or Cirrhosis
☐	AlcoholDrug Overuse/Abuse	☐	Herniated or Ruptured Disc
☐	Allergies or Hay Fever	☐	Herpes
☐	Anemia (low iron)	☐	High Blood Pressure
☐	Ankles swell frequently	☐	Hodgkin's Disease, Lymphoma, or Leukemia
☐	Anxiety or Panic Attacks	☐	Intolerance of dairy/fatty Foods
☐	Arthritis or Gout	☐	Irregular Heartbeat
☐	Asthma		
☐	Frequent Backaches	☐	Irritable Bowel Syndrome
☐	Bladder Infection	☐	Kidney Disease or Nephritis
☐	Blood Clots or Bleeding Prob.	☐	Kidney Stones
☐	Blood in Bowel Movement	☐	Lung Problems
☐	Blood Transfusion	☐	Lupus
☐	Boils or Cysts - Recurrent	☐	Malaria
☐	Bone or Joint Disease	☐	Seizures, Convulsions or Epilepsy
☐	Bowel or Colon Disease	☐	Meningitis
☐	Breast Lumps	☐	Migraine Headache
☐	Bronchitis - Recurrent	☐	Mole Changes
☐	Bruise Easily	☐	Muscle Disease or Weakness
☐	Bursitis or Tendonitis	☐	Pancreatitis
☐	Cancer	☐	Phlebitis
☐	Chest Pain	☐	Pleurisy
☐	Chills or night sweats	☐	Pneumonia
☐	Cholesterol-Elevated	☐	Polio
☐	Chronic Cough	☐	Problems with urination
☐	Colitis	☐	Rheumatoid Arthritis
☐	Color-blindness	☐	Rheumatic Fever
☐	Concerns about fertility	☐	Seizures, Convulsions or Epilepsy
☐	Concussion or Head Injury	☐	Sensory Changes
☐	Constipation	☐	Sexual Problems/Concerns
☐	Depression or Suicide	☐	Shortness or Breath
☐	Diabetes	☐	Sickle Cell Disease or Trait
☐	Difficulty swallowing	☐	Skin Disease - Chronic
☐	Dizziness or Fainting	☐	Skin Infections - Recurrent
☐	Emphysema	☐	Sleep Difficulties/Disorders
☐	Excessive Stress	☐	Sprains or Dislocations
☐	Frequent colds/sinus problems	☐	Stomach Pain
☐	Frequent earaches	☐	Stroke or Brain Attack
☐	Frequent or painful urination	☐	Swelling of joints
☐	Frequent/severe sore throat	☐	Thyroid Disease
☐	Frequent/severe nosebleeds	☐	Tremors/shaking of hands
		☐	Tuberculosis (TB) or positive test
☐	Gallbladder Disease or Gallstone	☐	Ulcer Disease or Gastritis
		☐	Unexpected weight loss
☐	Glaucoma	☐	Urinate frequently at night
		☐	Varicose Veins
☐	Gonorrhea, Syphilis or Chlamydia	☐	Venereal Disease
		☐	Wheezy or whistling chest
☐	Growth on skin	☐	Yellow Jaundice
☐	Gum bleed easily		
☐	Frequent/severe sore throat		
☐	Hearing Problems		

Name: _____ Date of Birth: _____

IMMUNIZATION HISTORY

			DATE OF LAST
Chickenpox or Shot	☐ Yes	☐ No	
Hepatitis B Series or Shots	☐ Yes	☐ No	
Influenza Shot	☐ Yes	☐ No	
Pneumonia Shot	☐ Yes	☐ No	
Rubella Shot or Blood Test	☐ Yes	☐ No	
Tetanus Shot	☐ Yes	☐ No	

FAMILY HISTORY

	If Alive, Age	If Dead, Age and Cause
Father		
Mother		
Brother/Sister		
Spouse/Sig Other		
Son(s)/Daughter(s)		

Primary Language in Home:

PLEASE CHECK FOR ANY CONDITION WHICH APPLIES TO A BLOOD RELATIVE

Condition	Who
Alcohol/Drug Abuse	
☐ Allergies/Asthma	
☐ Arthritis/Gout	
☐ Bleeding Disorder	
☐ Cancer (Type)	
☐ Diabetes	
☐ Epilepsy/Seizures	
☐ Glaucoma	
☐ Heart Disease	
☐ High Blood Pressure	
☐ High Cholesterol	
☐ HIV/AIDS	
☐ Kidney Disease	
☐ Mental Illness	
☐ Migraine Headaches	
☐ Sickle Cell Condition	
☐ Stroke	
☐ Suicide/Depression	
☐ Thyriod Disease	
☐ Other	

SOCIAL HISTORY

My current status is:

With whom do you now live?

Highest education achieved?

Your Occupaton?

Exposure to hazardous condition/substances at work? ☐ No ☐ Yes

Type:

Religious preference/beliefs:

Do you have a living will? ☐ No ☐ Yes

Are you an organ donor? ☐ No ☐ Yes

PERSONAL HISTORY

QUESTIONS FOR WOMEN ONLY:

MENSTRUATION:

Age periods began: How often:

Date of last menstrual period:

Now Pregnant?	☐ Yes	☐ No
Vaginal Discharge?	☐ Yes	☐ No
PMS?	☐ Yes	☐ No
Menopause?	☐ Yes	☐ No
Unexplained Vaginal Bleeding?	☐ Yes	☐ No
Discharge from nipples?	☐ Yes	☐ No
Skin changes in breasts?	☐ Yes	☐ No

PREGNANCIES:

Total Number: Full Term:

Date of last Pap Smear:

Date of last mammogram:

Premature:

Miscarriages:

Abortions:

Tubal Pregnancies:

QUESTIONS FOR MEN ONLY:

Prostate Trouble?	☐ Yes	☐ No
Discharge from penis?	☐ Yes	☐ No
Sore on penis?	☐ Yes	☐ No
Do you examine your testicles?	☐ Yes	☐ No

QUESTIONS FOR MEN AND WOMEN ONLY:

What kind of Birth Control/Protection do you and/or your partner use?

How would you describe your sexual orientation?

Do you use sunscreen?	☐ Yes	☐ No
Do you always wear seatbelts?	☐ Yes	☐ No
Do you wear protective sports equipment?	☐ Yes	☐ No
Is your house a smoke-free house?	☐ Yes	☐ No
Do you have a working smoke detector?	☐ Yes	☐ No
Are there any guns/weapons in your home?	☐ Yes	☐ No
Do you floss your teeth regularly?	☐ Yes	☐ No
Do you wear dentures?	☐ Yes	☐ No

Last dental visit? Date:

Do you wear glasses/contacts? ☐ Yes ☐ No

Last eye exam? Date:

DIET, EXERCISE & HABITS:

Do you follow a special diet? If so, explain:

Current Weight? Desired? One year ago?

What kind of exercise do you do and how often?

TOBACCO USE:

Do you smoke? What type:?

If yes, how much per day: Per week?

Have you quit smoking? When?

Do you use other tobacco products? Type:

If so, how much?

ALCOHOL USE:

Do you drink alcohol? How many drinks per week?

Has anyone ever expressed concerns about your alcohol use?

If yes, please explain: