**VA Weight Loss**
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Arjun Medical Center

# History Questionnaire

Name: _____ Date of Birth: _____ Date of visit: _____

Sex: M☐F☐Marital Status: _____ Email:_____

Last physical exam: _____ Occupation: _____

Reason for today's visit: _____

**Family Health History**

Please indicate the major medical conditions past and present of the following biological relatives including heart disease, high blood pressure, diabetes, cancer, etc. If deceased note age and cause.

- Father: _____
- Mother: _____
- Siblings: _____
  _____
  _____
- Children: _____
  _____
  _____

**Personal Illness**

Please indicate if you have had any of the following conditions:

| | | |
|---|---|---|
| ☐ Alcoholism | ☐ Drug abuse | ☐ Liver disease, hepatitis |
| ☐ Anemia | ☐ Easy bleeding | ☐ Measles, mumps, Rubella, or German measles |
| ☐ Asthma/emphysema/COPD | ☐ Eczema, hives, rashes | ☐ Stroke |
| ☐ Blood clots/Phlebitis | ☐ Epilepsy, seizures | ☐ Suicide attempt |
| ☐ Cancer, type: _____ | ☐ Eye problems | ☐ Thyroid disease |
| ☐ Chicken pox | ☐ Glaucoma | ☐ Ulcer in stomach |
| ☐ Depression | ☐ Heart disease | ☐ Other: _____ |
| ☐ Diabetes | ☐ High blood pressure | |

**Immunizations**

Circle those that you have had and enter the year of the most recent dose if known.
Flu: _____ Pneumococcal: _____ Prevnar: _____ Shingles: _____ Tetanus: _____

**Medication Allergies**

Please list the medication and type of reaction for each allergy.

_____ _____

_____ _____

**Hospitalization/surgery**

List illness or operations and approximate year. Exclude all normal pregnancies.

_____ _____

_____ _____

_____ _____

**Medications**

List all medications, including birth control, vitamins and other over the counter medications including the doses if known. Use the back of this sheet if needed.

_____ _____

_____ _____

_____ _____

_____ _____

**Other Medical History**

Current smoker? Yes☐ No☐ Former Smoker? Yes☐ No☐

If yes, what type: Cigars/Cigarettes How many per day? _____

Start year: _____ End year: _____ or Total # years: _____

Do you drink alcohol? Yes☐ No☐

If yes, what type? Beer/Wine/Liquor

How much and how often? _____ Daily/Weekly/Monthly

Do you use other drugs? Yes☐ No☐

Do you drink caffeine? Yes☐ No☐ How many cups per day? _____

Do you exercise? Yes☐ No☐

What types? _____

How many times per week? _____

**For Women Only**

# of pregnancies_____ # of live born children _____ # of Premature births ____

# miscarriages _____ # of still births _____

Date of last Pap smear: _____ Normal/Abnormal

Date of last Mammogram: _____ Normal/Abnormal

**Current Symptoms**

Please check the symptoms below that currently apply to you:

☐ Itchy or burning skin
☐ Dry or flaky skin
☐ Prolonged bleeding
☐ Easy bruising
☐ Fainting or feeling lightheaded
☐ Numbness in any part of the body
☐ Recent changes in handwriting
☐ Shaking or trembling of hands
☐ Frequent night time urination
☐ Black, brown or bloody urine
☐ Loss of control of urine
☐ Difficulty starting to urinate
☐ Feeling of not completely emptied the bladder
☐ Stiff or painful muscles or joints
☐ Swollen joint(s)
☐ Changes in bowel movements

- [ ] Nervous around strangers
- [ ] Difficulty making decisions
- [ ] Difficulty with concentration or memory
- [ ] Often feel lonely or depressed
- [ ] Cry often
- [ ] Hopeless outlook
- [ ] Sexual difficulties
- [ ] Thoughts of committing suicide
- [ ] Desired or sought psychiatric help
- [ ] Weight loss or gain
- [ ] Are you often too hot or too cold?
- [ ] Decreased interest in eating
- [ ] Do you always seem to be hungry?
- [ ] Increased thirst
- [ ] Swellings in your armpits or groin
- [ ] Are you exhausted or fatigued most of the time?
- [ ] Difficulty falling or staying asleep
- [ ] Snore at night
- [ ] Wake up still tired after a full night of sleep
- [ ] Frequently sleep during the day
- [ ] Fall asleep quickly at night
- [ ] Teeth grinding during sleep
- [ ] Frequent kicking or movements during sleep
- [ ] Heartburn
- [ ] Feel bloated after eating
- [ ] Frequent belching
- [ ] Stomach discomfort
- [ ] Frequently nauseated
- [ ] Ever vomited blood
- [ ] Difficult or painful swallowing
- [ ] Bleeding from the rectum
- [ ] Back or shoulder pain
- [ ] Painful feet
- [ ] Headaches more than once a week
- [ ] Pain with movement of the neck
- [ ] Cataracts
- [ ] Vision problems
- [ ] Hearing difficulty
- [ ] Motion sickness in cars or planes
- [ ] Dental problems
- [ ] Changes in taste
- [ ] Stuffy or runny nose
- [ ] Head cold for 2 or more months
- [ ] Nose bleeds
- [ ] Sore throat without a cold
- [ ] Enlarged tonsils
- [ ] Hoarse voice
- [ ] Wheezing
- [ ] Coughing spells
- [ ] Coughing blood
- [ ] Frequent sweating or night sweats
- [ ] High blood pressure now or in the past
- [ ] Thumping or racing heart
- [ ] Chest pain or tightness
- [ ] Dizziness or lightheadedness
- [ ] Shortness of breath
- [ ] Waking up at night feeling short of breath
- [ ] Swollen feet or ankles
- [ ] Leg cramps at night or with walking
- [ ] Heart murmur

| Men only | Women Only |
|---|---|
| ☐ Weak or slow urine stream | ☐ Bleeding after menopause |
| ☐ Enlarged prostate or other prostate problems | ☐ Heavy bleeding with periods |
| ☐ Burning or discharge from the penis | ☐ Bleeding between periods |
| ☐ Swelling or lumps in the testicles | ☐ Bleeding after intercourse |
| ☐ Painful testicles | ☐ Vaginal itching or discharge |
| ☐ Difficulty getting or maintaining an erection | ☐ Lumps or pain in breasts |
| | ☐ Complications with birth control |
| | ☐ Sexual difficulties |
| | ☐ Abnormal Pap smears or mammogram |