SANTA BARBARA INTERNAL MEDICINE GROUP
HEALTH QUESTIONNAIRE

Date:_____

Patient's Name:_____ Date of Birth: _____ Age: _____

Who referred you to us? _____

What is/are your chief symptom(s) or medical problem(s) at this time?

_____

Medical History
Please list any significant medical illnesses / surgical procedures / hospitalizations or injuries.

_____

_____

_____

Medications
Please list all medications that you are now taking. Check here if none

Name of Medication How taken? (pill, patch, etc.) How Often?

_____

_____

_____

_____

Immunization History
Date (most recent)

Tetanus _____

Pneumonia _____

TB skin test _____

Chicken Pox _____

Other _____

Allergies
Please list all medications that you are known to be allergic to. Check here if none

Name of Medication

_____

_____

_____

Habits
Have you ever used tobacco products? Yes No

Type_____ From:_____To:_____ Average daily amount: _____

Do you drink alcoholic beverages? Yes No

Type_____Average daily amount: _____

Do you consume any caffeine / caffeinated products? Yes No

Type_____Average daily amount: _____

Do you or have you used other drugs? Yes No

Please complete other side

Family History

Please list the health problems of your blood relatives. Please include:
Diabetes, high blood pressure, heart disease or heart attack, tuberculosis, cancer (indicate type) or alcoholism.

	Age	Health problems or cause of death	If deceased, age at death
Father			
Mother			
Brothers			
Sisters			
Children			

Social History

Marital Status: Single Married Widowed Divorced Separated

If married now, how long?_____ Previous marriages Yes No

With whom do you live? _____ How long have you lived in the local area?_____

Education:_____

Occupation(s) past and present:_____

Have you traveled outside of the U.S.A. in the past year? Yes No When/where?_____

Hobbies/interests:_____

Review of Systems Do you **currently** have any problems with the following:

Decreased Hearing	High Blood pressure	Bloody or tarry stools	Blood in urine
Ringing in ear	Heart murmur	Anemia or Bruise easily	Thyroid disease
Ear infections-frequent	Palpitations	Cancer	Convulsions / seizures
Dizzy spells Fainting spells	Irregular pulse	Diabetes	Strokes
Failing vision	Foot pain cold numb feet	Hemorrhoids	Tremor / hands shaking
Double or blurred vision	Gout	Gall bladder trouble	Muscle weakness
Eye pain	Swollen ankles	Jaundice / hepatitis	Numbness/tingling sensations
Eye infections-frequent	Leg pain when walking	Hernia	Headaches - frequent
Nose bleeds-frequent	Varicose veins / phlebitis	Weight loss - recent	Back pain - recurrent
Sinus trouble	Loss of appetite - recent	Chronic Fatigue	Bone fracture / joint injury
Sore throats - frequent	Difficulty swallowing	Urethral discharge	Rashes Hives
Asthma / wheezing	Indigestion or heartburn	Sexually transmitted disease	Psoriasis Eczema
Hayfever / allergies	Nausea / vomiting	Kidney stones	Sleeping - difficulty
Hoarseness	Peptic ulcers	Decreased force of urination	Memory Loss
Pneumonia / pleurisy	Abdominal pain - chronic	Control of urination	Moodiness
Bronchitis / chronic cough	Diahrrea Constipation	Urine infections - frequent	Phobias
Chest pain	Diverticulitis	Painful urination	Mental illness
Shortness of breath: on exertion lying flat	Change in bowel habits-recent	Overnight urination-more than 2	Nervousness Depression

Female menstrual history

Date of last menstrual period _____ Age at onset _____ Length of cycle _____ days

Regular Irregular Pain / crampswith menstrual flow Pain / bleeding after sex

Number of pregnancies ___ Number of live births ___ Number of terminated pregnancies ___ Number of miscarriages___

Birth control method _____ B.C. pill (name)_____

Flushing / Menopause Vaginal bleeding after

_____