

TEXAS OCCUPATIONAL MEDICINE INSTITUTE

HEALTH HISTORY QUESTIONNAIRE

Last Name _____ First Name _____ MI ____ Today's Date _____

Information for your physician

Please answer the following questions prior to your first examination. This will help your physician to know about your health.

Birthplace and date _____ Occupation _____

Single __ Married __ Separated __ Divorced __ Widowed __ Education _____

Who lives at home with you? _____

Medical History (Please check conditions you now have, or have had in the past):

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Seizures | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Acid Reflux/Ulcer | <input type="checkbox"/> Colon Disease | <input type="checkbox"/> Chest Injury |
| <input type="checkbox"/> Rib Fractures | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma/Emphysema |

Other Lung Disease (specify) _____

Hospitalizations (Please list all times in the hospital, for illness or surgery, beginning with the most recent)

Date	Reason	Hospital	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications (List all medicines you currently take, even those over-the-counter, including vitamins, supplements and herbal formulations)

Allergies: Have you had any allergy or sensitivity to medication or other substance? Yes __ No __

If yes, please list: _____

Lifestyle

Weight: Now _____ One year ago _____ Desired _____
Tobacco: Never _____ Age started _____ Age stopped _____
Cigarettes _____ (packs/day) Cigars _____ Pipe _____ Snuff _____ Chewing tobacco _____
Alcohol: Never _____ 0-6 drinks/week _____ 7-14 drinks/week _____ Over 14/week _____
Exposures to: Asbestos _____ Silica dust _____ Solvents _____ Chemicals _____ Isocyanates _____
Radiation _____ Fumes _____ Other _____

Family History (Check illnesses that have occurred in any of your blood relatives):

- Diabetes Cancer Heart Disease High Blood Pressure Asthma Emphysema Stroke
 Depression/Anxiety Allergies Other _____

Present health or cause of death:

Father _____ Mother _____
Siblings _____ Children _____