Victor Healthy Living
the place for healthcare

Gerald J Conezio, MD
internal medicine
(585) 924-7667

1331 East Victor Road
Victor, NY 14564
info@VictorHealthyLiving.com

HEALTH HISTORY QUESTIONNAIRE

Please print or type clearly.

Name: _____ Today's date: _____

❑ Male ❑ Female Birthdate: ____/____/____ Occupation: _____

Address: _____ City: _____ ZIP: _____

Email address: _____ Home phone: _____

Cell phone: _____ Work phone: _____

What are your major health concerns? _____

_____

Please check to answer the following questions.

	Yes	No	Don't Know
Do you smoke cigarettes?	❑	❑	❑
If previous or now, please answer: # of packs _____ # of years _____ Quit when _____ years old			
Do you smoke a pipe or cigars?	❑	❑	❑
Have you been diagnosed as having high blood pressure (hypertension)?	❑	❑	❑
Have either of your parents had high blood pressure?	❑	❑	❑
Did either of your natural parents die of heart trouble before the age of 55?	❑	❑	❑
Do you exercise three or more times a week so that your heart pounds for at least 10 minutes during each exercise period?	❑	❑	❑
Have you ever had breast cancer? (for men and women)	❑	❑	❑
Do you or any family member have a genetic predisposition to breast or ovarian cancer?	❑	❑	❑
Women: Have any blood relatives had breast cancer (on either side of your family)?	❑	❑	❑
If yes, please check: ❑ *mother* ❑ *grandmother* ❑ *sister* ❑ *daughter*			
Do you examine your breasts at least once a month (for women)	❑	❑	❑
If yes, are there any changes?	❑	❑	❑

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Please check to answer the following questions.	**Yes**	**No**	**Don't Know**
Did your mother take DES (diethylstilbestrol – a female hormone to prevent miscarriage) while she was pregnant with you? (for women)	❑	❑	❑
Have you ever been told you have a polyp in your bowel?	❑	❑	❑
Has your doctor ever told you that you have ulcerative colitis?	❑	❑	❑
Have you or any your blood relatives had cancer or polyp of the bowel?	❑	❑	❑
Do you know your cholesterol level?	❑	❑	❑
Have you had high cholesterol levels in the past?	❑	❑	❑
Do family members have cholesterol elevation?	❑	❑	❑
Do you drink alcoholic beverages?	❑	❑	❑
If yes, how many drinks do you usually have? (including beer, wine, whiskey, gin, vodka, etc.)	# per day		# per week
Has drinking ever caused you a problem? (health, legal, driving, family, or work)	❑	❑	❑
Has anyone ever commented on the way in which you drink? (past or present)	❑	❑	❑
Have your grandparents, parents, brothers, sisters, spouse or children ever had or now have a drinking problem? (circle which relative)	❑	❑	❑
Have you ever had radiation treatments or radiation exposure at work?	❑	❑	❑
Are you exposed to any chemicals or irritants at work?	❑	❑	❑
Do you wear a seatbelt whenever you are in a car, truck, or other moving vehicle?	❑	❑	❑
Circle one: Always Usually ½ the time Seldom Never			
Do you have a tattoo?	❑	❑	❑
Have you ever had a blood transfusion?	❑	❑	❑
Have you ever used illegal intravenous drugs?	❑	❑	❑
Have you ever had a sexually transmitted disease?	❑	❑	❑
Have you been with a prostitute?	❑	❑	❑
Do you have more than one sexual partner?	❑	❑	❑
Are you afraid of your partner?	❑	❑	❑
Is there violence at home?	❑	❑	❑
Do you have any guns in your home?	❑	❑	❑
Any difficulties with erections (men) or pain with sex?	❑	❑	❑
Are you currently using any form of birth control? (men & women and your partner)	❑	❑	❑
If yes, what? _____ ❑ Vasectomy ❑ Tubal ligation			

<u>Women only</u>

Number of pregnancies: _____ Deliveries: _____ Miscarriages: _____

Number of vaginal deliveries: _____ C-sections: _____

Children's names and ages:

Please check to answer the following questions.	Yes	No	Don't Know
Any problems with bladder control?	❑	❑	❑
Have you ever had an allergic reaction or side effect to any drug? (if yes, please list below in Column 1)	❑	❑	❑
Have you ever had any other allergic reactions – bee stings, asthma, severe poison ivy, etc.? (if yes, please list below in Column 2)	❑	❑	❑
Do you regularly or frequently take medications? (if yes, please list below in Column 3, including aspirin, vitamins, birth control pills, etc.)	❑	❑	❑

Column 1: Drug allergies & effects

1. _____
2. _____
3. _____
4. _____
5. _____

Column 2: Allergic reactions

1. _____
2. _____
3. _____
4. _____
5. _____

Colums 3: Medications

1. _____
2. _____
3. _____
4. _____
5. _____

How many siblings do you have, alive or deceased? Brothers: _____ Sisters: _____

Are all of your parents, brothers, sisters and children still alive? If no, please fill in below:

	Father	Mother	Siblings	Children
Age of death				
Cause of death				

Please mark the illnesses you have or previously had.

	Never	Previous	Now		Never	Previous	Now
Bleeding Tendency	❑	❑	❑	Gout	❑	❑	❑
Alcoholism	❑	❑	❑	Heart attack or Heart Disease	❑	❑	❑
Drug Addiction	❑	❑	❑	Hepatitis, Cirrhosis (Liver Disease)	❑	❑	❑
Chronic Bronchitis	❑	❑	❑	High Blood Pressure	❑	❑	❑
Emphysema	❑	❑	❑	Kidney or Bladder trouble	❑	❑	❑
Cancer or Tumor	❑	❑	❑	Severe Depression	❑	❑	❑
Increased Cholesterol	❑	❑	❑	Mental Illness	❑	❑	❑

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Please mark the illnesses you have or previously had.

	Never	Previous	Now		Never	Previous	Now
Colitis	❑	❑	❑	Pancreatitis	❑	❑	❑
Diabetes (Sugar)	❑	❑	❑	Recurrent Pneumonia	❑	❑	❑
Diverticulitis	❑	❑	❑	Polio	❑	❑	❑
Epilepsy or seizures	❑	❑	❑	Rheumatic Fever	❑	❑	❑
Gallbladder Disease	❑	❑	❑	Ulcer	❑	❑	❑
Stroke	❑	❑	❑	Sexually Transmitted Disease	❑	❑	❑
Thyroid Disease (Goiter)	❑	❑	❑	Tuberculosis or contact with TB	❑	❑	❑
Glaucoma	❑	❑	❑	Anemia	❑	❑	❑
Low Blood Sugar	❑	❑	❑	Lactose intolerance	❑	❑	❑
Crohn's Disease	❑	❑	❑				

Other: _____

Please mark the health problems which your family members, living and/or deceased, have had.

Identify: M – mother; F – father; S – sister; B – brother

	M	F	S	B		M	F	S	B		M	F	S	B
Bleeding Tendency	❑	❑	❑	❑	Heart Disease	❑	❑	❑	❑	Stroke	❑	❑	❑	❑
Diabetes (sugar)	❑	❑	❑	❑	High Blood Pressure	❑	❑	❑	❑	Cancer	❑	❑	❑	❑
Emphysema	❑	❑	❑	❑	Kidney Disease	❑	❑	❑	❑	Tuberculosis	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	Mental Illness	❑	❑	❑	❑	Other:	❑	❑	❑	❑
Cholesterol Elevation	❑	❑	❑	❑	Anesthesia Complications	❑	❑	❑	❑		❑	❑	❑	❑

Please list Hospitalizations, Surgeries, Biopsies, Fractures, or other serious injuries.

Nature of Problem Date Doctor's Name Hospital/Location

_____

_____

_____

_____

_____

_____

Need more room to list your information? Have a question?
Please tell a member of our office or nursing staff.

Welcome to Victor Healthy Living