New Patient - Health History Questionnaire
PASSER RESORATIVE THERAPIES/TRT INSTITUTE

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Name: Date of Birth: Today's Date:

Previous/Ongoing Medical Problems

◯ Allergies	◯ Diverticulosis	◯ Hernia	◯ Mononucleosis	◯ Stroke
◯ Asthma	◯ Eczema	◯ High Blood Pressure	◯ Mumps	◯ Tension/Anxiety
◯ Blood Clot	◯ Emphysema	◯ High Cholesterol	◯ Neuralgia or Neuritis	◯ Thyroid Disease
◯ Blood clotting problems	◯ Eye Infections	◯ High Cholesterol	◯ Osteoporosis	◯ Tuberculosis
◯ Blood Transfusion	◯ Gastroesophageal Reflux	◯ Hives or Rashes	◯ Osteoporosis	◯ Ulcers
◯ Bronchitis	◯ Genetic Disease	◯ Kidney Disease	◯ Pancreatitis	◯ Yellow Jaundice
◯ Cancer or Tumor	◯ Glaucoma	◯ Kidney/Bladder trouble	◯ Pneumonia	◯ _____
◯ Chicken Pox	◯ Gout	◯ Liver Disease	◯ Prostate Problems	◯ _____
◯ Constipation	◯ Heart Trouble	◯ Measles	◯ Pulmonary Disease	
◯ Depression	◯ Hemorrhoids	◯ Mental illness	◯ Rheumatism or Arthritis	
◯ Diabetes	◯ Hepatitis	◯ Migraines	◯ Sexually Transmitted Disease	

Surgical: Previous Surgeries/Procedures

◯ None
◯ Appendectomy
◯ Biopsy of _____ ◯ Right ◯ Left ◯Benign ◯ Malignant
◯ Cardiac Surgery: _____
◯ Carpal Tunnel: ◯ Right ◯ Left ◯ Bilateral
◯ Cataract: ◯ Right ◯ Left ◯ Bilateral
◯ Gallbladder
◯ Hip Replacement: ◯ Right ◯ Left ◯ Bilateral
◯ Hysterectomy: ◯ Uterus Only ◯ Uterus and Ovaries
◯ Knee Replacement: ◯ Right ◯ Left ◯ Bilateral
◯ Mastectomy: ◯ Right ◯ Left ◯ Bilateral
◯ Prostatectomy
◯ Radiation Therapy: _____
◯ Thyroidectomy
◯ Tonsillectomy
◯ Colonoscopy Last one? _____
◯ Mammogram Last one? _____
◯ Other: _____

MAJOR HOSPITALIZATIONS

If you have been hospitalized for any major medical issues or operations, please write your four ***most recent*** hospitalizations. (*Do not include normal pregnancies.*)

◯ Check here if you have had ***more than four*** such hospitalizations.

	Year	Operation or Illness	Name of Hospital	City and State
1st Hospitalization				
2nd Hospitalization				
3rd Hospitalization				
4th Hospitalization				

New Patient - Health History Questionnaire (cont.)

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Family History

- ◯ Unknown
- ◯ I have no family history of heart disease, cancer or other serious illness.
- ◯ Heart Disease Who and what kind? _____
- ◯ Cancer Who and what kind? _____
- ◯ Other: _____

Social History (Circle One)

Marital Status: Single Married Domestic Partner Divorced Separated Widowed

Children: Number of Children _____

Education-Occupation: Highest Level of Education: GED Graduated High School Some College Graduated College Trade School

Military Service: Yes No Branch? _____ How long? _____

Present Employment Status: Full Time Part Time Retired Disability

Current Employer: _____ Occupation: _____ How long? _____

Do you have physical work restrictions? Yes No If yes, what are they? _____

Exercise: None Daily Weekly _____ X per week Type? _____

Hobbies: _____

Alcohol Use: Do you use alcohol? None Yes, _____ # of drinks per.....day week month

Do you have a history of alcoholism, drug abuse, or addiction? Yes No

Do you use recreational drugs? Yes No If yes, please list: _____

Tobacco Use: No, Never

Yes How much? __Pack __Can __Cigar ___per day for ___ years

Former Use Stopped on: _____ How much did you use? __Pack __Can __Cigar ___per day for ___ years

Caffeine Use: None Minimal Moderate Heavy

Incarceration: Any history of incarceration? Yes No

Religious Preference: _____

Diet: No Specific Diabetic Low Fat Low Salt Vegetarian Weight Reduction Other: _____

Are you currently sexually active? Yes No

Now in the blank lines below, describe any special problems or symptoms that you wish to discuss with the doctor.

_____

_____

_____

The above information is true to the best of my knowledge: *(signature)* _____