CCOAA – FULL HEALTH HISTORY QUESTIONNAIRE

Name: ____________________ **DOB:** __________ **Appointment Date**: __________

Who is your Primary Care Physician (not group/practice please): ____________________

Did he/she refer you to us? Yes No **If no, who did?** ____________________

Who are your other Physicians? __________ __________ __________

GENERAL MEDICAL INFORMATION

What is the main reason you are here today? ____________________

Patient's Weight (Lbs) __________ Height __________

List all current medical conditions (treated and untreated) __________ __________

__________ __________ __________ __________

List ALL Surgeries (include year)

__________ __________

__________ __________

__________ __________

List ALL Hospitalizations (include year)

__________ __________

__________ __________

__________ __________

List ALL Medications & doses (include over the counter)

__________ __________ __________

__________ __________ __________

__________ __________ __________

List ALL Allergies (drugs, food, environmental)

__________ __________

__________ __________

__________ __________

FAMILY HISTORY: Please circle if there is a history of the following in parents, siblings or grandparents (GP):

Mother	☐ Hearing Loss	☐ Diabetes	☐ Heart Disease	☐ Thyroid disease / Cancer	☐ Bleeding / Bruising
Father	☐ Hearing Loss	☐ Diabetes	☐ Heart Disease	☐ Thyroid disease / Cancer	☐ Bleeding / Bruising
Siblings	☐ Hearing Loss	☐ Diabetes	☐ Heart Disease	☐ Thyroid disease / Cancer	☐ Bleeding / Bruising
Maternal GM	☐ Hearing Loss	☐ Diabetes	☐ Heart Disease	☐ Thyroid disease / Cancer	☐ Bleeding / Bruising
Paternal GM	☐ Hearing Loss	☐ Diabetes	☐ Heart Disease	☐ Thyroid disease / Cancer	☐ Bleeding / Bruising
Maternal GF	☐ Hearing Loss	☐ Diabetes	☐ Heart Disease	☐ Thyroid disease / Cancer	☐ Bleeding / Bruising
Paternal GF	☐ Hearing Loss	☐ Diabetes	☐ Heart Disease	☐ Thyroid disease / Cancer	☐ Bleeding / Bruising

Name: ________________________________ **DOB:** ____________ **Appointment Date:** ____________

SOCIAL HISTORY:

Do or Did you ever smoke/chew/cigars/pipe? YES /NO When did you quit? ____________________

Did you ever take recreational/street drugs? YES /NO What, how much & when ______________________

Do you drink alcohol? YES / NO Ounces per day ______________________________

Caffeine intake (coffee, tea, ice tea, chocolate) per day__________________________

What kind of work do you do? ____

FOR CHILDREN: Is your child up to date with immunizations? YES / NO

REVIEW OF SYMPTOMS

Please CIRCLE YES for any of the following diseases or symptoms you have experienced RECENTLY:

Constitutional:	Fevers	YES	Weight Loss	YES
	Night Sweats	YES	Are you pregnant	YES
EAR:	Hearing Loss	YES	Ringing	YES
	Ear Infections	YES	Dizziness	YES
NOSE:	Bleeding	YES	Congestion	YES
THROAT:	Soreness	YES	Difficulty Swallowing	YES
LARYNX:	Hoarseness	YES	Throat Clearing	YES
SINUS:	Pain	YES	Frequent Infections	YES
DENTAL:	TMJ problems	YES		
CVS:	Chest Pain	YES		
PULM:	Cough	YES	Shortness of Breath	YES
GI:	Heartburn	YES	Painful Swallowing	YES
MSK:	Neck Pain	YES		
PSY:	Anxiety	YES		
DERM:	Hives	YES		
ENDO:	Thyroid Problems	YES	Thyroid Cancer	YES
NEUR:	Numbness of the face	YES	Weakness of the face	YES
EYES:	Visual Changes	YES		
ID:	Seasonal Allergies	YES		
HEME:	Bleeding/Bruising	YES	Swollen Glands	YES
GU:	Kidney Stones	YES		

Other ____