



SENIOR
HEALTH ALLIANCE

Galichia Heart
HOSPITAL

Member ID #: _____

Original Date: _____

Dates Revised: _____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME (last, first, MI):		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:	SSN:
ADDRESS:			PHONE #:	
MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> PARTNERED				
RESPONSIBLE PARTY:			SPOUSE:	
ADDRESS OF RESPONSIBLE PARTY IF OTHER THAN SELF:				
RETIRED: <input type="checkbox"/> EMPLOYER:			PHONE:	
ADDRESS:		CITY, STATE:		ZIP:
EMERGENCY CONTACT:		PHONE:	RELATIONSHIP:	

INSURANCE INFORMATION

MEDICARE: <input type="checkbox"/> YES <input type="checkbox"/> NO	GROUP #:	I.D. #:
MEDICARE: <input type="checkbox"/> YES <input type="checkbox"/> NO	GROUP #:	I.D. #:

SECONDARY INSURANCE CARRIER

COMPANY:	GROUP #:	I.D. #:
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PERSONAL HEALTH HISTORY

ALLERGIES TO MEDICATIONS

NAME THE DRUG	REACTION YOU HAD

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

NAME THE DRUG	STRENGTH	FREQUENCY TAKEN

SURGERIES		
YEAR	REASON	HOSPITAL

OTHER HOSPITALIZATIONS		
YEAR	REASON	HOSPITAL

BLOOD PRESSURE: HIGH <input type="checkbox"/> LOW <input type="checkbox"/>	CHOLESTEROL:	UNKNOWN: <input type="checkbox"/>
BLOOD TYPE: A: <input type="checkbox"/> B: <input type="checkbox"/> A/B: <input type="checkbox"/> O: <input type="checkbox"/>	HAVE YOU EVER HAD A BLOOD TRANSFUSION?: <input type="checkbox"/> YES <input type="checkbox"/> NO	

All questions contained in this questionnaire are optional and will be kept strictly confidential.

HEALTH HISTORY FOR SELF AND FAMILY

CODES: MOTHER - M, FATHER - F, BROTHER/SISTER - S, GRANDPARENT - GP									
	SELF	FAMILY	WHEN? (YEAR)	WHO TREATED? (PHYSICIAN)		SELF	FAMILY	WHEN? (YEAR)	WHO TREATED? (PHYSICIAN)
ANEMIA					ENLARGED HEART				
ARTHRITIS					EPILEPSY				
ASTHMA / EMPHYSEMA					FAINTING SPELLS				
BACK DISORDERS					GALLSTONES				
VOMITED BLOOD					GALL BLADDER PROBLEM				
BLACK TARRY STOOL					GLAUCOMA				
BLEEDING DISEASE					HEADACHES				
BLOOD IN STOOL					HEART ATTACK				
BLOOD IN URINE					HEART DISEASE				
CANCER					HEART MURMUR / VALVE				
CHANGE IN BOWEL HABITS					HEPATITIS				
CHEST PAIN					HIGH BLOOD PRESSURE				
COPD					HIV (AIDS)				
CONSTIPATION					INDIGESTION				
CORONARY ARTERY DISEASE					FREQUENCY URINATION AT NIGHT				
COUGH					IRREGULAR HEART BEAT				
COUGHING BLOOD					KIDNEY INFECTION				
DEPRESSION					KIDNEY STONE				
DIABETES					LEG PAIN				
DIARRHEA					LUNG DISEASE				
DIFFICULTY SWALLOWING					LYME DISEASE				
DIZZINESS					MITRAL VALVE PROLAPSE				
PHLEBITIS					PAINFUL URINATION				
PLEURISY					PARALYSIS				
PNEUMONIA					SWELLING OF FEET				
VENEREAL DISEASE					SWOLLEN JOINTS				
RHEUMATIC FEVER					T.B. (TUBERCULOSIS)				
FEVER					PAINFUL JOINTS				
SHORTNESS OF BREATH					THYROID DISEASE				
SLEEP DISORDER					ULCER				
STROKE					OTHER				

OTHER PROBLEMS