

**Dan F. Bautista, M.D., LLC**  
**HEALTH QUESTIONNAIRE**

*(To be completed by patient)*

TODAY'S DATE.....

NAME.....

DATE OF BIRTH..... AGE.....

DRUG ALLERGIES.....

**CHIEF COMPLAINTS** *(Please list in order of importance, present health concerns, symptoms, or problems you are experiencing)*

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 .....  
 .....

**HOSPITALIZATIONS** *(If you have been in the hospital overnight, state year, illness/operation. Do not include pregnancies.)*

YEAR	ILLNESS/SURGERY	YEAR	ILLNESS/SURGERY

**PAST MEDICAL HISTORY** *(Have you ever had the following, circle YES or NO, leave blank, if uncertain)*

AIDS/HIV+	Y	N	Glaucoma	Y	N	Pneumonia	Y	N
Anemia	Y	N	Heart Disease	Y	N	Polio	Y	N
Arthritis	Y	N	Hemorrhoids	Y	N	Rheumatic	Y	N
Asthma	Y	N	Hepatitis	Y	N	Scarlet fever	Y	N
Back trouble	Y	N	Hernia	Y	N	Smallpox	Y	N
Bladder infections	Y	N	High or low B/P	Y	N	Stroke	Y	N
Bleeding tendency	Y	N	Hives or eczema	Y	N	Thyroid disease	Y	N
Bronchitis	Y	N	Infectious Mono	Y	N	Transfusions	Y	N
Cancer	Y	N	Kidney Disease	Y	N	Tuberculosis	Y	N
Chickenpox	Y	N	Measles	Y	N	Ulcer	Y	N
Diabetes	Y	N	Migraines	Y	N	Venereal disease	Y	N
Diphtheria	Y	N	Mitral valve	Y	N	Whooping cough	Y	N
Epilepsy	Y	N	Mumps	Y	N	Any other disease	Y	N
Depression	Y	N	Anxiety Disorder	Y	N			

OTHER ILLNESS, Explain:

.....  
 .....

**FAMILY HISTORY** *(Has any blood relative had any of the following: circle YES or NO, leave blank if uncertain)*

	Y	N	RELATIONSHIP		Y	N	RELATIONSHIP
Allergies/Asthma	Y	N	.....	Epilepsy	Y	N	.....
Anemia	Y	N	.....	Heart Disease	Y	N	.....
Bleeding tendency	Y	N	.....	High blood Pressure	Y	N	.....
Cancer	Y	N	.....	Stroke	Y	N	.....
Diabetes	Y	N	.....	Others			.....

**MEDICATIONS**

**DOSAGE**

**TIMES/DAY**

.....

.....

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**SOCIAL HISTORY**

Tobacco                    Y     N     Packs per day.....for .....years

Alcohol                    Y     N     Drinks per day.....

Caffeine                    Y     N     Cup per day.....

Illegal Drugs              Y     N     Type.....

Marital Status.....

Occupation.....

**The last time you had a (list year)**

Flu vaccine.....	Tetanus shot.....
Hepatitis vaccine.....	TB test.....
Pneumonia shot.....	Rubella vaccine.....
Stool blood test.....	Rectal exam.....
Sigmoid exam.....	Eye exam.....
Cholesterol test.....	PSA.....

<b>HEARING HEALTH</b>		
Do others complain that you watch television with the volume too high?	Yes	No
Do you frequently have to ask others to repeat themselves?	Yes	No
Do you have difficulty understanding when in groups or in noisy situations?	Yes	No
Do you have to sit up front in meetings or in church in order to understand?	Yes	No
Do you difficulty understanding women or young children?	Yes	No
Do you have trouble knowing where sounds are coming from?	Yes	No
Are you able to understand when someone talks to you from another room?	Yes	No
Have others told you that you don't seem to hear them?	Yes	No
Do you avoid meetings or social situations because you "can't understand"?	Yes	No
Do you have ringing or other noises (tinnitus) in you ears?	Yes	No

<b>FOR WOMEN ONLY</b>	
Age at onset of menstrual period.....	.....
Date of last menstrual period.....	.....
Use birth control     Y     N     Type.....	.....
Number of pregnancies.....	Number of live births.....
Number of abortions.....	Number of miscarriages.....
<b>Year of last:</b>	
Breast exam.....	Results.....
Mammogram.....	Results.....
Pap.....	Results.....