Please answer the following questions to the best of your ability:

## *PERSONAL HEALTH HISTORY*

**What medications are you taking now?** _____

_____

**Are you allergic to any medications? Which ones? What does the medication do to you?** _____

_____

**What major illnesses, surgeries, and/or hospitalizations have you had?**

| Illness/Surgery/Reason for Hospitalization | Date |
|---|---|
| | |
| | |
| | |

**Have you ever had or have you now:**

| | | | | | |
|---|---|---|---|---|---|
| High Blood Pressure | ☐yes ☐no | Polyps | ☐yes ☐no | Hepatitis | ☐yes ☐no |
| Diabetes | ☐yes ☐no | Cancer | ☐yes ☐no | AIDS | ☐yes ☐no |
| Heart Disease | ☐yes ☐no | TB | ☐yes ☐no | Gallstones | ☐yes ☐no |
| Stroke | ☐yes ☐no | Arthritis | ☐yes ☐no | Thyroid Disease | ☐yes ☐no |
| Anemia | ☐yes ☐no | Ulcers | ☐yes ☐no | Mental Illness/Depression | ☐yes ☐no |

**Have you had any of these problems lately:**

| | | | | | |
|---|---|---|---|---|---|
| Weight Loss | ☐yes ☐no | Chest Pain | ☐yes ☐no | Backache | ☐yes ☐no |
| Excessive Thirst | ☐yes ☐no | Palpitations | ☐yes ☐no | Abdominal Pain/Heartburn | ☐yes ☐no |
| Frequent Urination | ☐yes ☐no | Shortness of Breath | ☐yes ☐no | Joint Pain | ☐yes ☐no |
| Headaches | ☐yes ☐no | Prolonged Cough | ☐yes ☐no | Pain on Urination | ☐yes ☐no |
| Fainting | ☐yes ☐no | Loss of Hearing | ☐yes ☐no | Blood in Urine | ☐yes ☐no |
| Depression | ☐yes ☐no | Loss of Vision | ☐yes ☐no | Abnormal or Bloody Stools | ☐yes ☐no |

**Do you smoke Cigarettes?** ☐smoke now how much?_____ ☐used to smoke ☐never

**Do you drink more than two alcoholic drinks a day?** ☐yes ☐no

**Do you use recreational drugs?** ☐yes ☐no

**What is your occupation?** _____ **Have you recently been injured at work?** ☐yes ☐no

## *FAMILY HEALTH HISTORY*

**Has anyone in your family had or currently have:**

| | | | | | |
|---|---|---|---|---|---|
| Cancer | ☐yes ☐no | Diabetes | ☐yes ☐no | TB | ☐yes ☐no |
| Heart Disease | ☐yes ☐no | High Blood Pressure | ☐yes ☐no | other: | ☐yes ☐no |

## *HEALTH MAINTENANCE*

**What immunizations have you had:**

| | | | | | |
|---|---|---|---|---|---|
| Pneumovax (Pneumonia) | ☐yes ☐no | Tetanus/Diphtheria | ☐yes ☐no | Mumps/Measles/Rubella | ☐yes ☐no |

**WOMEN ONLY - Have you had within the last six months:**

| | | | | | |
|---|---|---|---|---|---|
| Breast Lump or Discharge | ☐yes ☐no | Vaginal Itching or Discharge | ☐yes ☐no | Abnormal Menstrual Bleeding | ☐yes ☐no |

**Date of last menstrual period:** _____ **Date of last PAP Smear:** _____

**Date of last mammogram:** _____ **Do you use contraception?** ☐yes ☐no If yes, type _____

"I hereby certify that to the best of my knowledge, the foregoing answers are complete and correct."

_____ _____
Patient Signature Date Provider Signature Date

Hun Kang M.D.
Family Practice
2900 West 8th Street
Los Angeles CA 90005
213-382-7022

Patient Name _____
Last First M.I.

DOB _____ Medical Record # _____

Social Security/CSC Number _____

# Patient History Questionnaire