WOLLSCHLAEGER EXHIBIT 2

Aventura Family Health Center

HEALTH HISTORY QUESTIONNAIRE

Date _____ Name_____ DOB_____

Please answer every question on both sides of the following pages.

Please check any of the following medical problems that you have had.

☐Abn. Weight Loss
☐Abn. Weight Gain
☐Excessive Fatigue
☐Insomnia
☐Anemia
☐Cancer or Tumor

☐Glasses/ Contacts
☐Glaucoma
☐Cataracts
☐Other Problems with vision

☐Hearing Loss
☐Ear Problems
☐Ringing in Ears

☐Allergies
☐Frequent Sinus Infections

☐Dentures
☐Dental Problems
☐Recurrent Sores in Mouth

☐Angina
☐Frequent Chest Pain
☐Irregular Heartbeat
☐Heart Murmur

☐Rheumatic Fever
☐High Cholesterol
☐Heart Failure
☐Heart Attack
☐High Blood Pressure

☐Breathing Problems
☐Frequent Bronchitis
☐Emphysema
☐Pneumonia
☐Asthma

☐Heartburn
☐Ulcer Disease
☐Gallbladder Disease
☐Blood in Stool
☐Hepatitis
☐Diarrhea, Constipation, or other changes in bowel habits
☐Hemorrhoids
☐Abdominal Pain
☐Colon Polyp

☐Urinary Frequency
☐Bladder Infections
☐Prostate Problems
☐Urinary Incontinence
☐Kidney Problems

☐Arthritis or joint pain
☐Gout
☐Broken Bones

☐Rashes
☐Hives
☐Moles

☐Seizure
☐TIA
☐Stroke
☐Numbness
☐Weakness
☐Memory Loss
☐Headaches

☐Depression
☐Anxiety/ Panic Attacks
☐Suicide Attempt
☐Physical Abuse
☐Sexual Abuse
☐Mental Illness

☐Diabetes
☐Thyroid Disease
☐Sexually Transmitted Diseases

☐Abnormal Pap smear
☐Abnormal Mammogram
☐Breast Lump
___#Pregnancies
___ Live Births
___ Miscarriages
___ Abortions

Have you been exposed to or do you have a close family member with...

☐HIV/AIDS
☐Hepatitis
☐TB

Other medical problems:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List ***all*** surgeries you have had:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List ***all*** medication allergies:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List ***all*** medications, vitamins, and supplements you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

List ***all*** health care providers you have seen in the past or are currently seeing:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

(Continued on back)

Please list the last year in which you have had any of the following:

Physical Exam _____ Sigmoidoscopy/Colonoscopy (circle which one) _____ Cholesterol _____
Pap Smear _____ Stool Cards for Colon Cancer _____ Dental Visit _____
Mammogram _____ Rectal/Prostate Exam _____ Eye exam _____
Testicular Exam_____ Bone Density_____ Stress Test_____

Please list the last year in which you have had any of the following.

Tetanus _____ Pneumonia shot _____ Hepatitis B series _____
Flu shot _____ PPD (TB test) _____ Measles, Mumps, Rubella (MMR) _____

Please describe your use of tobacco products.

☐ None ☐ Cigarettes ☐ Smokeless Tobacco ☐ Pipe ☐ Cigars
How much do you or did you smoke _____ per day? For how many years _____?
Do you wish to quit? ☐ Now ☐ Soon ☐ Eventually ☐ Never
Have you quit? _____ When? _____

How much alcohol do you drink weekly on average? _____
Do you have a problem with alcohol? ☐ Yes ☐ No

Have you used illicit drugs (marijuana, heroin, cocaine, LSD, etc)? ☐ Yes ☐ No

How much caffeine do you drink daily (include coffee, tea, colas)? _____

Are you sexually active? _____ Are your partners male, female, or both? (circle)
Do you use contraception? ☐ None ☐ Rhythm ☐ Condoms ☐ Pill ☐ Vasectomy ☐IUD ☐Diaphragm ☐ Tubal Ligation
Do you practice safe sex? ☐ Never ☐ Sometimes ☐ Always

Have you ever had a blood transfusion? ☐ Yes ☐ No if Yes, what year _____?

What is your marital status? ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner

Are you currently... ☐ Employed ☐ Unemployed ☐ Self Employed ☐ Retired
What is or was your occupation? _____

Please check which of the following behaviors you follow.

☐ Wear seatbelt ☐ Wear helmet while riding bike or motorcycle ☐ Smoke detector in house
☐ Fire Extinguisher in house ☐ Perform Self-Breast Exam Regularly ☐ Perform Self Testicular Exam
☐ Living Will or Advanced Directive ☐ Frequent exposure to animals (cats, dogs, other) ☐ Low Fat diet
☐ Exercise more than 3 times per week

Please check if there is a history of any of the following diseases in your family.

☐ Heart Disease ☐ Diabetes ☐ Colon Cancer ☐Osteoporosis ☐Prostate Cancer
☐ Breast Cancer ☐ Ovarian Cancer ☐ High Cholesterol ☐ Skin Cancer

Please fill in the following family history.

	Age (or age at death)	Medical Problems
Father		
Mother		
Siblings		
Children		

Patient Signature _____ Date _____

Physician Signature _____ Date _____