North Queensland X-RAY services

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HEALTH HISTORY QUESTIONNAIRE

Name:	DOB:	M ☐ F ☐

Have had any of the following surgeries **(please tick)**

☐ Caesarian	☐ Cholecystectomy (Gall Bladder)	☐ Prostatectomy
☐ Hysterectomy	☐ Spinal surgery **(please list)**	☐ Thyroidectomy
☐ Tubal Ligation	☐ Bypass	☐ Stent
☐ Oophorectomy (Ovaries removed)	☐ Hernia Repair	☐ Tonsillectomy
☐ Cystoscopy	☐ Testicular surgery	☐ Prolapse surgery
☐ Mastectomy	☐ Appendectomy	☐ Breast Implants
☐ Hip arthroscopy/replacement	☐ Shoulder arthroscopy/replacement	☐ Knee arthroscopy/replacement

Please list any other surgeries you may have had,

Have you had any of the following diagnosed illnesses **(please tick)**

☐ Diabetes	☐ Prostate Disease	☐ Crohn's Disease	☐ Hepatitis
☐ Asthma	☐ Cancer **(please list)**	☐ Anemia	☐ Tuberculosis
☐ Emphysema	☐ Gynecological Disease	☐ Thyroid Disease	☐ Multiple Sclerosis
☐ High Blood pressure	☐ Kidney Disease	☐ Dementia	☐ HIV
☐ Heart Disease **(please list)**	☐ Lung Disease **(please list)**	☐ Reflux	☐ Irritable Bowel
☐ Coeliac	☐ Hearing Loss	☐ Diverticulitis	☐ Eye disease
☐ Epilepsy	☐ Arthritis	☐ Vertigo	☐ Stroke

Please list any other illness you may have,

Are you allergic to any of the following **(please tick)**

☐ Aspirin	☐ Latex	☐ Band aids/tape
☐ Anti-inflammatory	☐ Iodine	☐ Food allergy (Please list)
☐ Antibiotics	☐ Seafood/Shellfish	☐ Hay fever

Please list any other allergies you may have,

Women only

Date of the first day of your last period:	Are you pregnant: ☐ Y ☐ N
Number of Pregnancies:	Are you breast feeding: ☐ Y ☐ N
Number of Live Births:	Are you experiencing any breast tenderness, lumps or nipple discharge of your breasts? ☐ Y ☐ N