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HEALTH HISTORY QUESTIONNAIRE

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

Name (Last, First, M.I.): ◯ M ◯ F	**DOB:**
Marital status: ◯ Single ◯ Partnered ◯ Married ◯ Separated ◯ Divorced ◯ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Past Medical History: Please check all you have had problems with or are presently experiencing any of the following:

☐ High Blood Pressure	☐ Ulcers	☐ Indigestion	☐ Colitis	☐ Skin disease
☐ Diabetes	☐ Bronchitis Cancer	☐ Nausea	☐ Hepatitis or Jaundice	☐ Blood disorders
☐ Cancer	☐ Pneumonia	☐ Kidney stones	☐ Thyroid disease	☐ Venereal disease
☐ Heart Disease	☐ Cough	☐ Change in bowel habits	☐ Headaches/Migraines	☐ Anxiety
☐ Chest pain/palpitations	☐ Tuberculosis (T.B.)	☐ Weight loss/gain	☐ Drug Abuse	☐ Anemia
☐ Shortness of breath	☐ Hay Fever	☐ Hemorrhoids	☐ Arthritis	☐ Alcohol Abuse
☐ Swollen ankles/Gout	☐ Stomach pains	☐ Gall bladder disease	☐ Low back pain	

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ◯ Yes ◯ No

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Immunizations and dates:	Tetanus	Date:	Pneumonia	Date:
	Hepatitis	Date:	Chickenpox	Date:
	Influenza	Date:	MMR Measles, Mumps, Rubella	Date:

List your prescribed drugs and over-the-counter drugs, such as vitamins, herbs and inhalers		
Name the Drug	Dosage	Frequency Taken

Allergies to medications, X-Ray dyes, latex, or other substances	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	◯ Sedentary (No exercise)					
	◯ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	◯ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	◯ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				◯ Yes	◯ No
	If yes, are you on a physician prescribed medical diet?				◯ Yes	◯ No
	# of meals you eat in an average day?					
	Rank salt intake	◯ Hi	◯ Med	◯ Low		
	Rank fat intake	◯ Hi	◯ Med	◯ Low		
Caffeine	None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				◯ Yes	◯ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				◯ Yes	◯ No
	Have you considered stopping?				◯ Yes	◯ No
	Have you ever experienced blackouts?				◯ Yes	◯ No
	Are you prone to "binge" drinking?				◯ Yes	◯ No
	Do you drive after drinking?				◯ Yes	◯ No

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Tobacco	Do you use tobacco?			Yes	No
	Cigarettes – pks./day	Chew - #/day	Pipe - #/day	Cigars - #/day	
	# of years	Or year quit			
Drugs	Do you currently use recreational or street drugs?			Yes	No
	Have you ever given yourself street drugs with a needle?			Yes	No
Sex	Are you sexually active?			Yes	No
	If yes, are you trying for a pregnancy?			Yes	No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?			Yes	No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?			Yes	No
Personal Safety	Do you live alone?			Yes	No
	Do you have frequent falls?			Yes	No
	Do you have vision or hearing loss?			Yes	No
	Do you have an Advance Directive or Living Will?			Yes	No
	Would you like information on the preparation of these?			Yes	No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?			Yes	No

FAMILY HEALTH HISTORY

PLEASE CHECK ALL THAT APPLY

		AGE	CANCER (TYPE)	HIGH BLOOD PRESSURE	HEART DISEASE	DIABETES	STROKES	DRUG/ALCOHOL ABUSE	GLAUCOMA	BLEEDING DISEASE	OTHER (EXPLAIN)
Father				☐	☐	☐	☐	☐	☐	☐	
Mother				☐	☐	☐	☐	☐	☐	☐	
Sibling	M F			☐	☐	☐	☐	☐	☐	☐	
	M F			☐	☐	☐	☐	☐	☐	☐	
	M F			☐	☐	☐	☐	☐	☐	☐	
	M F			☐	☐	☐	☐	☐	☐	☐	
	M F			☐	☐	☐	☐	☐	☐	☐	
	M F			☐	☐	☐	☐	☐	☐	☐	
Grandmother Maternal				☐	☐	☐	☐	☐	☐	☐	
Grandfather Maternal				☐	☐	☐	☐	☐	☐	☐	
Grandmother Paternal				☐	☐	☐	☐	☐	☐	☐	
Grandfather Paternal				☐	☐	☐	☐	☐	☐	☐	
Children	M F			☐	☐	☐	☐	☐	☐	☐	
	M F			☐	☐	☐	☐	☐	☐	☐	
	M F			☐	☐	☐	☐	☐	☐	☐	
	M F			☐	☐	☐	☐	☐	☐	☐	

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MENTAL HEALTH

Is stress a major problem for you?	Yes	No
Do you feel depressed?	Yes	No
Do you panic when stressed?	Yes	No
Do you have problems with eating or your appetite?	Yes	No
Do you cry frequently?	Yes	No
Have you ever attempted suicide?	Yes	No
Have you ever seriously thought about hurting yourself?	Yes	No
Do you have trouble sleeping?	Yes	No
Have you ever been to a counselor?	Yes	No

WOMEN ONLY

Date of last pap and rectal exam?	Date of last Mammogram?
Date of last breast exam?	Date of last Colonoscopy?

MEN OVER 40 ONLY

Date of last prostate and rectal exam
Last time your stool was checked for blood?
Date of last Colonoscopy?