HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1.	
2.	
3.	

PHARMACY

Address _____

City _____ St_____ Zip_____

Phone _____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

IMMUNIZATION HISTORY

Immunizations and most recent date:

- ☐ Chickenpox Date:_____
- ☐ Flu Shot Date:_____
- ☐ Gardasil/HPV Date:_____
- ☐ Hepatitis A Date:_____
- ☐ Hepatitis B Date:_____
- ☐ Meningococcus Date:_____
- ☐ MMR *(Measles, Mumps, Rubella)* Date:_____
- ☐ Pneumonia Date:_____
- ☐ Tdap *(Tetanus and pertussis)* Date:_____
- ☐ Tetanus Date:_____
- ☐ Zostavax *(Shingles)* Date:_____

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ ☐ Abnormal

Last Mammogram Date _____ ☐ Abnormal

Age of first menstrual period: _____

Date of last menstrual period or age of menopause: _____

Number of pregnancies: _____ births: _____

miscarriages: _____ abortions: _____

☐ Cesarean sections If yes, then number: _____

- ☐ Bleeding between periods
- ☐ Heavy periods
- ☐ Extreme menstrual pain
- ☐ Vaginal itching, burning, or discharge
- ☐ Wake in the night to go to the bathroom
- ☐ Hot flashes
- ☐ Breast lump or nipple discharge
- ☐ Painful intercourse
- ☐ Sexually active
  - Current sexual partner is ☐ Female ☐ Male
  - Do you use condoms ☐ Yes ☐ No
  - Other Birth control method used:_____

☐ Interested in being screened for STD's

PAST MEDICAL HISTORY

Please check all that apply:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots (or DVT)
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Claustrophobic
- ☐ Diabetes - Insulin
- ☐ Diabetes - Non-Insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Has Pacemaker
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hiatal Hernia or Reflux Disease
- ☐ HIV or AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Overactive Thyroid
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Reflux or Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other

PAST SURGICAL HISTORY

	SURGERY	REASON	YEAR	HOSPITAL
1.				
1.				
3.				
4.				

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (maternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandmother (paternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (paternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Father	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Mother	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Other:_____	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke

SOCIAL HISTORY

Education ☐ Less than 8th grade
☐ High school
☐ 2 year college ☐ 4 year college
☐ Post graduate

Marital Status ☐ Married ☐ Single
☐ Divorced ☐ Separated ☐ Widowed
☐ Domestic partner

Exercise Level
☐ None (No exercise)
☐ Occasional exercise
☐ Moderate exercise
☐ High level exercise

Caffeine ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
# of cups/cans per day? ____

Alcohol Do you drink alcohol?
☐ Yes ☐ No
If so, how often?
☐ Occasionally ☐ < 3 times a week
☐ > 3 times a week
How many drinks per week? __

Tobacco Do you use tobacco?
☐ Yes ☐ No

If not currently, did you ever use tobacco? ☐ Yes ☐ No
☐ Cigarettes -____pks./day
☐ Chew - _____/day
☐ Cigars - _____/day
☐ # of years____
Or year quit _____

Drugs Do you currently use recreational or street drugs? ☐ Yes ☐ No
If yes, list:
_____
_____

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic
☐ Frequent Sneezing
☐ Hives
☐ Itching
☐ Runny Nose
☐ Sinus Pressure

Cardiovascular
☐ Arm Pain on Exertion
☐ Chest Pain on Exertion
☐ Chest Heaviness/Pressure on Exertion
☐ Irregular Heart Beats (Palpitations)
☐ Known Heart Murmur
☐ Light-headed on Standing
☐ Shortness of Breath When Lying Down
☐ Shortness of Breath When Walking
☐ Swelling (edema)

Constitutional
☐ Exercise Intolerance
☐ Fatigue
☐ Fever
☐ Weight Gain (____lbs)
☐ Weight Loss (____lbs)

Eyes
☐ Dry Eyes
☐ Irritation
☐ Vision Change
Date of Last Exam:_____

Ears/Nose/Mouth/Throat
☐ Bleeding Gums
☐ Difficulty Hearing
☐ Dizziness
☐ Dry Mouth
☐ Ear Pain
☐ Frequent Infections
☐ Frequent Nosebleeds
☐ Hoarseness
☐ Mouth Breathing
☐ Mouth Ulcers
☐ Nose/Sinus Problems
☐ Ringing in Ears

Endocrine
☐ Fatigue
☐ Increased Thirst/Hunger/Urination

Gastrointestinal
☐ Abdominal Pain
☐ Black or Tarry Stool
☐ Blood in Stool
☐ Change in Appetite
☐ Frequent Indigestion
☐ Hemorrhoids
☐ Trouble Swallowing
☐ Vomiting
☐ Vomiting Blood

Genitourinary
☐ Blood in Urine
☐ Difficulty Urinating
☐ Incomplete Emptying
☐ Increased Urinary Frequency
☐ Urinary Loss of Control

Hematologic/Lymphatic
☐ Easy Bruising/Bleeding
☐ Swollen Glands

Integumentary (Skin)
☐ Changes in Moles
☐ Dry Skin
☐ Eczema
☐ Growth/Lesions
☐ Itching
☐ Jaundice (Yellow Skin/Eyes)
☐ Rash

Musculoskeletal
☐ Back Pain
☐ Joint Pain
☐ Muscle Aches
☐ Muscle Weakness

Neurological
☐ Dizziness
☐ Fainting
☐ Headaches
☐ Memory Loss
☐ Migraines
☐ Numbness
☐ Restless Legs
☐ Seizures
☐ Weakness

Psychiatric
☐ Alcohol Overuse
☐ Anxiety/Stress
☐ Depression
☐ Do Not Feel Safe in Relationship
☐ Mania
☐ Sleep Problems

Respiratory
☐ Cough
☐ Coughing Up Blood
☐ Shortness of Breath
☐ Sleep Apnea
☐ Snoring
☐ Wheezing

Please add any other information about your health that you would like your provider to know here:

Patient, Parent, Guardian, or Caregiver Signature

Date