**Health History Questionnaire**

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| **Name**: (Last,First,M.I.): | | | **DOB**: |
| **Sex**:M  F | **Occupation**: | | |
| **Marital Status**:  Single  Partnered Married  Separated  Divorced  Widowed | | | |
| **Previous or referring doctor:** | | **Date of last physical exam**: | |
| **How did you hear about out office**:  Patient Referral  Insurance Company  Newspaper Ad  Yellow pages  Internet Search  Other: | | | |

**Personal Health History**

**Immunizations and dates**:  Tetanus: \_\_\_\_\_\_\_\_\_  TDAP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Pneumonia: \_\_\_\_\_\_\_\_\_\_  Prevnar: \_\_\_\_\_\_\_\_\_\_\_

Hepatitis A:\_\_\_\_\_\_\_  Hepatitis B:\_\_\_\_\_\_\_\_\_\_  Chickenpox:\_\_\_\_\_\_\_\_\_\_  Influenza:\_\_\_\_\_\_\_\_\_\_\_

MMR:\_\_\_\_\_\_\_\_\_\_\_

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| **Medical History:** | | |
| Allergies | Elevated Cholesterol | Mumps |
| Anemia | Frequent infections | Osteoporosis |
| Arthritis | Gallbladder disease | Peripheral Vascular Disease |
| Asplenia | GERD | Pneumonia |
| Asthma | GI disorders | Polio |
| Bowel irregularity | Gout | Pregnancy currently |
| Bronchitis | Headache | Prostate Disease |
| Cancer | Heart Disease | Renal dysfunction |
| Chronic liver disease | Heart murmur | Rheumatic Fever |
| Chronic rashes | Heart palpitations | Scarlett Fever |
| Clotting disorder | Hepatitis | Sexually Transmitted Disease |
| COPD | HIV Infections | Sickle Cell Disease |
| Coronary Artery Disease | Hypertension | Stroke/TIA |
| Depression | Illicit drug use | Tetanus |
| Developmental Disability | Immediately postpartum | Thyroid Disorder |
| Diabetes Mellitus | Iron deficiency | Ulcer |
| Diet related illness (obesity) | Lactose intolerance | Other |
| Diphtheria | Measles |  |
| Dizziness/Fainting | Menopausal or postmenopausal |  |

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| **Surgeries:** | | |
| *Year* | *Reason* | *Hospital* |
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| **Other Hospitalizations:** | | |
| *Year* | *Reason* | *Hospital* |
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| **List your prescribed drugs and over-the-counter drugs, such as vitamins**: | | |
| *Name of drug* | *Strength* | *Frequency Taken* |
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| **Allergies:** | | |
| *Name of drug* | *Reaction you had* | |
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| **Family Health History:  Adopted/Unknown** | | |
| *Relative* | *Age* | *Significant Health Problems* |
| Father Living Deceased |  |  |
| Mother Living Deceased |  |  |
| Siblings | M ☐  F ☐ |  |
| M  F |
| Maternal Grandmother |  |  |
| Maternal Grandfather |  |  |
| Paternal Grandmother |  |  |
| Paternal Grandfather |  |  |

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| **Screening for Men & Women:** | | |
| *Test* | *Date* | *Result* |
| Colonoscopy |  |  |
| Bone Density |  |  |
| Rectal Exam |  |  |
| Mammography |  |  |
| Complete blood tests |  |  |
| Test for blood in stool |  |  |
| Pelvic and pap test (women only) |  |  |
| Chest x-ray |  |  |
| PSA |  |  |

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| **Social History:** | | | | | |
| Exercise | No Exercise Mild exercise (i.e. climb stairs, walk 3 blocks)  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 min) | | | | |
| 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 day? | | | | |
| Tobacco | Do you use tobacco? | | | | Yes No |
| Cigarettes – Pks./day | Chew-#/day | Pipe-#/day | Cigars-#/day |
| # of years | | Or year quit | |
| Drugs | Do you want to discuss any drug use with your provider? | | | | Yes No |
| Sex | Are you sexually active? | | | | Yes No |
| Do you live alone? | | | | |
| Do you have a glasses? | | | | Yes No |
| Personal Safety | Do you have hearing aids? | | | | Yes No |
| Do you have an advance directive and/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 |
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| **Women Only:** | |
| Age at onset of menstruation: Period every days | |
| Date of last menstruation: | |
| Heavy periods, irregularity, spotting, pain, or discharge? | Yes No |
| Number of pregnancies: Number of live births: | |
| Are you pregnant or breastfeeding? | Yes No |
| Have you had a D&C, hysterectomy, or Cesarean? | Yes No |
| Any urinary tract, bladder, or kidney infections within the last year? | Yes No |
| Any hot flashes or sweating at night? | Yes No |
| Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? | Yes No |
| Experienced any recent breast tenderness, lumps, or nipple discharge? | Yes No |

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| **Men Only:** | |
| Do you often get up to urinate during the night? | Yes No |
| Any blood in your urine? | Yes No |
| Any difficulty with erection or ejaculation? | Yes No |