Health History Questionnaire

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:_____

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	

Surgeries:		
Year	*Reason*	*Hospital*
Other Hospitalizations:		
Year	*Reason*	*Hospital*

List your prescribed drugs and over-the-counter drugs, such as vitamins:		
Name of drug	*Strength*	*Frequency Taken*
Allergies:		
Name of drug	*Reaction you had*	

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		

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		

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

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

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