



## HEALTH HISTORY QUESTIONNAIRE

Name ( <i>Last, First, M.I.</i> )		<input type="checkbox"/> M <input type="checkbox"/> F	Height:	DOB:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
Previous or Referring Doctor:			Date of Last Physical Exam:	
Main Reason for Your Visit Today:				
<b>Please list any significant medical conditions you have had, past or present:</b>				
<b>Surgeries</b>				
Year	Reason		Hospital	
<b>Other Hospitalizations</b>				
Year	Reason		Hospital	
<b>Preventative Care</b>				
	Date		Date	Date
<input type="checkbox"/> Colonoscopy		<input type="checkbox"/> Pap Smear (Women)		<input type="checkbox"/> Cholesterol Level
<input type="checkbox"/> Bone Density		<input type="checkbox"/> Mammogram (Women)		<input type="checkbox"/> Other
<b>Immunizations</b>				
	Date		Date	Date
<input type="checkbox"/> Tetanus Td or Tdap (Circle One)		<input type="checkbox"/> Hepatitis B		<input type="checkbox"/> Influenza
<input type="checkbox"/> Hepatitis A		<input type="checkbox"/> HPV (Gardasil)		<input type="checkbox"/> Shingles (Zostavax)
<input type="checkbox"/> Pneumovax				

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 Last Name, First Name

## HEALTH HABITS AND PERSONAL SAFETY

<b>Exercise</b>	Regular Exercise is any planned physical activity (e.g., brisk walking, aerobics, jogging, bicycling, swimming, rowing, etc.) performed to increase physical fitness. Such activity should be performed 4 to 5 times per week for 20-60 minutes per session. Exercise does not have to be painful to be effective but should be done at a level that increases your breathing rate and causes you to break a sweat.		
	Do you do Regular Exercise according to the above definition?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Days per week:		
	Minutes per session:		
<b>Diet</b>	Are you on a special diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you eat a healthy diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea <input type="checkbox"/> Soda
	# of cups/cans per day?		
<b>Alcohol</b>	Do you drink alcohol?		
	If yes, what kind?		
	How many drinks per week?		
	Have you ever felt the need to cut down on drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever been annoyed by criticism of your drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever felt guilty about your drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever felt the need for an eye-opener?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Tobacco</b>	Do you use or have you ever used tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes - pk/day:	<input type="checkbox"/> Chew - #/day:	<input type="checkbox"/> Pipe - #/day: <input type="checkbox"/> Cigars - #/day :
	# of years:	Year quit:	
<b>Drugs</b>	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Sex</b>	Are you sexually active?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have more than one partner?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are your partner(s) <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both		
	If not trying for a pregnancy, list contraceptive or barrier method used:		
	Do you have any questions or concerns about sexually transmitted diseases?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you live alone?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have frequent falls?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have a vision or hearing loss?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have an Advance Directive or Living Will? If you would like one, please ask your physician.		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you wear seatbelts?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any concerns about physical, mental or sexual abuse that you would like to discuss with the physician?		<input type="checkbox"/> Yes <input type="checkbox"/> No

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 Last Name, First Name

**FAMILY HEALTH HISTORY**

Did/do they have diabetes, high blood pressure, cancer, high cholesterol, heart disease, thyroid disease, asthma, migraines, Alzheimer's, drug or alcohol abuse, other (list)					
	Age		Age	Significant Health Problems	
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
<b>Mother</b>				<input type="checkbox"/> M	
				<input type="checkbox"/> F	
<b>Brothers/ Sisters</b>	<input type="checkbox"/> M		Grandmother		
	<input type="checkbox"/> F		<i>Maternal</i>		
	<input type="checkbox"/> M		Grandfather		
	<input type="checkbox"/> F		<i>Maternal</i>		
	<input type="checkbox"/> M		Grandmother		
	<input type="checkbox"/> F		<i>Paternal</i>		
	<input type="checkbox"/> M		Grandfather		
	<input type="checkbox"/> F		<i>Paternal</i>		

**MENTAL HEALTH**

Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought of hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, for what problem?		

**MEDICATIONS**

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to Medications		
Name the Drug	Reaction You Had	

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*Last Name, First Name*

**√ CHECK to the left of symptom if you have now or in the recent past:**

Constitutional	Gastrointestinal	Cardiovascular
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Swallowing problem	<input type="checkbox"/> Chest pain or pressure
<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Fevers	<input type="checkbox"/> Bloating	<input type="checkbox"/> Wake up breathless
<input type="checkbox"/> Significant Weight change	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Ankle swelling
Head Neck neuro	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Leg cramping
<input type="checkbox"/> Vision changes	<input type="checkbox"/> Nausea	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Headaches	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Cold feet or hands
<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Passing out
<input type="checkbox"/> Dizziness or vertigo	<input type="checkbox"/> Constipation	Musculoskeletal
Ear, Nose, Throat	<input type="checkbox"/> Bowels irregular	<input type="checkbox"/> Joint stiffness
<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Joint pain
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Black stool	<input type="checkbox"/> Joint swelling
<input type="checkbox"/> Sinus – Nose bleeds	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Muscle aches
<input type="checkbox"/> Oral lesions	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Weakness
<input type="checkbox"/> Neck or jaw pain	Genitourinary	<input type="checkbox"/> Change in moles
<input type="checkbox"/> Lumps in Neck	<input type="checkbox"/> Menstrual trouble	<input type="checkbox"/> Rashes-Bump-Bruises
Respiratory	<input type="checkbox"/> Menopause	<input type="checkbox"/> Numbness
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Tingling
<input type="checkbox"/> Cough	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Low back pain
<input type="checkbox"/> Sputum	<input type="checkbox"/> Urge to urinate	<input type="checkbox"/> Blood clots-Phlebitis
<input type="checkbox"/> Coughed up blood	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Deformity/Amputation
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Blood in urine	
<input type="checkbox"/> Snoring	<input type="checkbox"/> Discharge	
<input type="checkbox"/> Breathless with walking	<input type="checkbox"/> Awakening to urinate	
<input type="checkbox"/> Breathless when flat in bed	<input type="checkbox"/> Change in stream	
	<input type="checkbox"/> Lumps in testicles	

**ALLERGIES**

Do you experience any of these symptoms more than twice per year: Cough, cold, congestion, difficulty breathing, headaches, wheezing, runny nose, sore throat, itchy/irritated eyes, unexplained fatigue, sinus pain, ear pain, skin irritation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been diagnosed with asthma or bronchitis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you experience symptoms of allergies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
We offer allergy testing and no-shot allergy treatment at this office. Would you like to find out more about this?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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 Patient Signature

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 Date