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	**D.O.B.**
RACE/ETHNICITY ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Native American ☐ Asian ☐ Other ☐ More than 1 ☐ I prefer not to answer ☐ I'm not sure	**MARITAL STATUS** ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered/Married
Previous or Referring Doctor:	**Date of last Physical Exam:**

PERSONAL HEALTH HISTORY

Childhood Illness:

☐ Measles ☐ Mumps ☐ Rubella ☐Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and Dates:

Tetanus_______ Hepatitis _______ Influenza _______ Pneumonia _______ MMR *Measles, Mumps, Rubella* _______

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

SURGERIES:

Year	Reason	Hospital

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OTHER HOSPITALIZATIONS:

Year	Reason	Hospital

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

FAMILY HEALTH HISTORY

	AGE / SIGNIFICANT HEALTH PROBLEMS		AGE / SIGNIFICANT HEALTH PROBLEMS
Father		**Grandmother** *Maternal*	
Mother		**Grandfather** *Maternal*	
Sibling	**M** **F**	**Grandmother** *Paternal*	
	M **F**	**Grandfather** *Paternal*	
	M **F**	**Children**	**M** **F**
	M **F**		**M** **F**
			M **F**
			M **F**

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PERSONAL SAFETY		
Do you live alone?	☐ Yes	☐ No
Do you have frequent falls?	☐ Yes	☐ No
Do you have 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

MENTAL HEALTH		
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 injuring yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No

SEX		
If not trying for pregnancy, list contraceptive barrier method used:		
Are you sexually active?	☐ Yes	☐ No
If yes, are you trying for pregnancy?	☐ Yes	☐ No
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: intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of illness?	☐ Yes	☐ No

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WOMEN ONLY		
Age at onset of menstruation:		
Date of last menstruation:		
Period every ________ days:		
Number of pregnancies _____ Number of live births _____ Abortions/Miscarriages: _____		
Date of last pap or rectal exam?		
Heavy periods, irregularity, spotting, pain or discharge?	☐ Yes	☐ No
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 blood urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ 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
Experiences any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No

MEN ONLY		
Do you usually get up to urinate during the night?	Yes	No
If yes, # of times ___________________		
Do you feel pain or burning with urination?	Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
☐ Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?		

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OTHER PROBLEMS		
☐ Skin	☐ Chest/Heart	**Recent Changes in:**
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy Level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other Pain/Discomfort
☐ Lungs	☐ Circulation	

PRESCRIPTION MEDICATION, OVER-THE-COUNTER, VITAMINS, INHALERS		
Name of the Drug:	**Strength:**	**Frequency Taken:**

ALLERGIES TO MEDICATIONS		
Name of the Drug:	**Reaction you had**	

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CAFFEINE			
☐ None	☐ Coffee	☐ Tea	☐ Cola

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

TOBACCO			
Do you use tobacco?		☐Yes	☐ No
☐ Cigarettes – Pks./day ________	☐ Chew #/day _________	☐ Pipe - #/day ___________	☐ Cigars - #/day ____________
☐ # of Years _____________	☐ or Year that you quit: ___________		

RECREATIONAL DRUGS		
Do you currently use recreational or street drugs?	☐ Yes	☐ No
Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No

EXERCISE	
Sedentary (No Exercise)	☐
Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)	☐
Occasional vigorous exercise (i.e., work or recreation, less than 4 x week for 30 min.)	☐
Regular vigorous exercise (i.e., work or recreation 4 x week for 30 min.)	☐

DIET		
Are you dieting?	☐ Yes	☐ No
If yes, are you on a physician prescribed medical diet?	☐ Yes	☐ No
# of meals you eat in average per day: ________________		
Rank Salt Intake ☐ Hi ☐ Medium ☐ Low		
Rank Fat Intake ☐ Hi ☐ Medium ☐ Low		