HEALTH HISTORY QUESTIONNAIRE

PriMED PHYSICIANS
Treating You Well

Name _____ **Date of Birth** _____

Date Completed _____

What is the major focus of your visit? _____

What symptoms are you having? _____

What other topics would you like to discuss if there is time? _____

Medical History

Current and Past Medical Problems

□ High Blood Pressure	□ Anxiety	□ Hepatitis A, B or C	□ Stomach Ulcers
□ Diabetes	□ Depression	□ Liver Disease	□ Vision Disorder
□ Heart Failure	□ Bipolar Disorder	□ Menstrual Disorder	□ Hearing Disorder
□ Heart Attack	□ Schizophrenia	□ Prostate Disorder	□ Pancreatitis
□ High Cholesterol	□ Suicide Attempt	□ Bladder Disorder	□ Irritable Bowel Disease
□ Asthma	□ Alcohol/Drug Issues	□ Migraine Headaches	□ Ulcerative Colitis/Crohn's
□ COPD (Emphysema)	□ Rheumatoid Arthritis	□ Anemia	□ Sexually Transmitted Disease
□ Kidney Disease	□ Acid Reflux/GERD	□ Seizure Disorder	□ HIV/Aids
□ Cancer: _____	□ Thyroid: High/Low	□ Dementia	□ Blood Clots
□ Stroke/TIA	□ Gout	□ Osteoporosis/Osteopenia	□ Bleeding Disorder

Others or Details: _____

Current Medications

Medication Name	Dose	Times per day	Physician

Specialists treating you? _____

Drug Allergies

Drug	Reaction	Drug	Reaction

Surgery (Example: Tonsils, Appendix, Gallbladder, Hysterectomy, Joint Replacement/Arthroscopy, Heart, Tubal, D&C, Cataracts)

Year	Operation	Physician

Other: _____

Name _____ **Date of Birth** _____

Hospitalizations (Example: Heart: attack/cath/stent, stroke, blood clots, pneumonia, major trauma, pancreatitis, hepatitis, bleeding)

Year	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other: _____

Women

Age First menstruation: _____ Date Last Menstruation: _____ Number of Pregnancies: _____ Number Live Births: _____

History of Abnormal Pap ☐ Yes ☐ No

Men & Women

Sexually Active: ☐ Yes ☐ No ☐ Not now With: ☐ Men ☐ Women ☐ Both

Type of Contraception: _____

History of Any Source of Abuse: ☐ Yes ☐ No _____

Other Concerns: _____

Blood Transfusions

☐ Yes ☐ No Year of transfusion _____ Other: _____

Social History

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed

Number of Children: _____ Number of Grandchildren: _____

Others who live with you:_____

Housing:_____

Occupation is/was: _____

Graduated: ☐ High School ☐ College ☐ Advanced degree

Tobacco/Vaping: ☐ Yes ☐ No How much? _____ How long? _____ When did you Quit? _____

Alcohol/Drugs: ☐ Yes ☐ No How much? _____ How long? _____ When did you Quit? _____

Special diet: ☐ Yes ☐ No What kind of diet? _____

Exercise: ☐ Yes ☐ No How much? _____ How long? _____ What type? _____

Do you have a faith tradition or cultural background that influences you or your health care decisions? ☐ Yes ☐ No

Which ones? _____

Do you have a Living Will? ☐ Yes ☐ No

Do you have a Durable Power of Attorney for Health Care (not a regular power of attorney)?

☐ Yes ☐ No Who? _____

Family History

Put Check in Box if Yes (√)

	Father	Mother	Siblings	Children	Father's Parents	Mother's Parents			Father	Mother	Siblings	Children	Father's Parents	Mother's Parents
Hypertension								Depression						
Diabetes								Alcoholism						
Heart Attack								Seizures						
Stroke								Glaucoma						
Breast Cancer								Bleeding or Blood Clots						
Ovarian Cancer								Psychiatric Disorder						
Colon Cancer								High Cholesterol						
Prostate Cancer								Malignant Melanoma						

Other: _____