# HEALTH HISTORY QUESTIONNAIRE

Please complete this entire questionnaire. It will provide your care team with important information about your health.
All answers contained in this questionnaire are strictly confidential and will become part of your medical record.

**Name** *(Last, First, M.I.)*:______________________ ☐ M ☐ F **DOB:**______________

**Date:**______________ **Marital status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

**Number of children:**________ **How many live with you?**________ **Occupation is/was:**______________

**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________ ☐ Pneumonia________ ☐ Hepatitis________ ☐ Chickenpox________

☐ Influenza________ ☐ MMR *Measles, Mumps, Rubella*________ ☐ Meningococcal________

**Tests/Screenings and Dates:** ☐ Eye Exam________ ☐ Colonoscopy________ ☐ Mammogram________ ☐ Dexa Scan________

**Surgeries**

Year__________ Reason______________________________ Hospital______________

Year__________ Reason______________________________ Hospital______________

Year__________ Reason______________________________ Hospital______________

Year__________ Reason______________________________ Hospital______________

☐ I have had no surgeries

**Other hospitalizations**

Year__________ Reason______________________________ Hospital______________

Year__________ Reason______________________________ Hospital______________

Year__________ Reason______________________________ Hospital______________

Year__________ Reason______________________________ Hospital______________

☐ I have never been hospitalized

**Have you ever had a blood transfusion?** ☐ Y ☐ N

**Please list other physicians you have seen in the last 12 months, and for what reason.**

____________________________________________

____________________________________________

____________________________________________

____________________________________________

____________________________________________

Name (Last, First, M.I.):______________________________ DOB ______________

## YOUR MEDICAL HISTORY

Please indicate if **YOU** have a history of the following:

- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anesthetic Complication
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Problems
- ☐ Birth Defects
- ☐ Bladder Problems
- ☐ Bleeding Disease
- ☐ Blood Clots
- ☐ Blood Transfusion(s)
- ☐ Bowel Disease
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Colon Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Growth/Development Disorder
- ☐ Hearing Impairment
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Pain/Angina
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ H IV
- ☐ Hives
- ☐ Kidney Disease
- ☐ Liver Cancer
- ☐ Liver Disease
- ☐ Lung Cancer
- ☐ Lung/Respiratory Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Prostate Cancer
- ☐ Rectal Cancer
- ☐ Reflux/GERD
- ☐ Seizures/Convulsions
- ☐ Severe Allergy
- ☐ Sexually Transmitted Disease
- ☐ Skin Cancer
- ☐ Stroke/CVA of the Brain
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Ulcer
- ☐ Visual Impairment
- ☐ Other Disease, Cancer, or Significant Medical Illness
- ☐ NONE of the Above

**List other past medical problems:**______________________________

______________________________

______________________________

**If you are a new patient, list your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers . For current patients, please make any changes or additions below or on the enclosed Medication List.**

Drug ______________ Dose/Frequency__________ Drug______________ Dose/Frequency __________

Drug ______________ Dose/Frequency__________ Drug______________ Dose/Frequency __________

Drug ______________ Dose/Frequency__________ Drug______________ Dose/Frequency __________

Drug ______________ Dose/Frequency__________ Drug______________ Dose/Frequency __________

☐ I take no medications, vitamins, herbals, or any other over-the-counter preparations

**Allergies**

Name______________________________ Reaction You Had ______________________________

☐ I have no known **drug** allergies

## FAMILY MEDICAL HISTORY

Please indicate if **YOUR FAMILY** has a history of the following: *(**ONLY** include parents, grandparents, siblings, and children)*

- ☐ Family History Unknown
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anesthetic Complication
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Problems
- ☐ Bleeding Disease
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Lung/Respiratory Disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Other Cancer
- ☐ Rectal Cancer
- ☐ Seizures/Convulsions
- ☐ Severe Allergy
- ☐ Stroke/CVA of the Brain
- ☐ Thyroid Problems
- ☐ NONE of the Above
- ☐ Mother, Grandmother, or Sister developed heart disease before the age of 65
- ☐ Father, Grandfather, or Brother developed heart disease before the age of 55

Name (Last, First, M.I.):______________________________ DOB ______________

## SOCIAL HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

**Exercise**
- ☐ Sedentary (No exercise)
- ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
- ☐ 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 minutes)

**Diet**
Are you dieting? ☐ Y ☐ N If yes, are you on a physician prescribed medical diet?........ ☐ Y ☐ N
# of meals you eat in an average day?____________
Rank salt intake ☐ Hi ☐ Med ☐ Low
Rank fat intake ☐ Hi ☐ Med ☐ Low

**Caffeine** ☐ None ☐ Coffee ☐ Tea ☐ Cola # of cups/cans per day?____________

**Alcohol**
Do you drink alcohol?........ ☐ Y ☐ N
If yes, what kind?______________________ How many drinks per week?____________
Are you concerned about the amount you drink?........ ☐ Y ☐ N
Have you considered stopping?........ ☐ Y ☐ N
Have you ever experienced blackouts?........ ☐ Y ☐ N
Are you prone to "binge" drinking?........ ☐ Y ☐ N
Do you drive after drinking?........ ☐ Y ☐ N

**Tobacco**
Do you use tobacco?........ ☐ Y ☐ N
☐ Cigarettes – pks./day_________ ☐ Chew - #/day_________ ☐ Pipe - #/day_________ ☐ Cigars - #/day_________
☐ # of years_________ ☐ Or year quit_________

**Drugs**
Do you currently use recreational or street drugs?........ ☐ Y ☐ N
Have you ever given yourself street drugs with a needle?........ ☐ Y ☐ N
☐ I prefer to discuss with the physician

**Sex**
Are you sexually active?........ ☐ Y ☐ N
If yes, are you trying for a pregnancy?........ ☐ Y ☐ N
If not trying for a pregnancy list contraceptive or barrier method used:______________________
Any discomfort with intercourse?........ ☐ Y ☐ N
Illness related to Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?........ ☐ Y ☐ N

**Mental Health**
Is stress a major problem for you?........ ☐ Y ☐ N
Do you feel depressed?........ ☐ Y ☐ N
Do you panic when stressed?........ ☐ Y ☐ N
Do you have problems with eating or your appetite?........ ☐ Y ☐ N
Do you cry frequently?........ ☐ Y ☐ N
Have you ever attempted suicide?........ ☐ Y ☐ N
Have you ever seriously thought about hurting yourself?........ ☐ Y ☐ N
Do you have trouble sleeping?........ ☐ Y ☐ N
Have you ever been to a counselor?........ ☐ Y ☐ N

Name (Last, First, M.I.):______________________________ DOB ______________

## Personal Safety

Do you live alone? ☐ Y ☐ N

Do you have frequent falls? ☐ Y ☐ N

Do you have vision or hearing loss? ☐ Y ☐ N

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? ☐ Y ☐ N

How often do you have sun exposure? ☐ Occasionally ☐ Frequently ☐ Rarely

Have you ever experienced a sunburn? ☐ Y ☐ N

How often do you wear your seatbelt? ☐ Occasionally ☐ Frequently ☐ Always

**These questions are for WOMEN ONLY**

Age at onset of menstruation:__________ Date of last menstruation:__________ Period every__________days

Heavy periods, irregularity, spotting, pain, or discharge? ☐ Y ☐ N

Number of pregnancies:__________ Number of live births:__________

Are you pregnant or breastfeeding? ☐ Y ☐ N

Have you had a D&C, hysterectomy, or Cesarean? ☐ Y ☐ N

Any urinary tract, bladder, or kidney infections within the last year? ☐ Y ☐ N

Any blood in your urine? ☐ Y ☐ N

Any problems with control of urination? ☐ Y ☐ N

Any hot flashes or sweating at night? ☐ Y ☐ N

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? ☐ Y ☐ N

Do you perform monthly breast self exams? ☐ Y ☐ N

Experienced any recent breast tenderness, lumps, or nipple discharge? ☐ Y ☐ N

Date of last pelvic exam:______________________

**These questions are for MEN ONLY**

Do you usually get up to urinate during the night? ☐ Y ☐ N

Do you feel pain or burning with urination? ☐ Y ☐ N

Any blood in your urine? ☐ Y ☐ N

Do you feel burning discharge from penis? ☐ Y ☐ N

Has the force of your urination decreased? ☐ Y ☐ N

Have you had any kidney, bladder, or prostate infections within the last 12 months? ☐ Y ☐ N

Do you have any problems emptying your bladder completely? ☐ Y ☐ N

Any difficulty with erection or ejaculation? ☐ Y ☐ N

Any testicle pain or swelling? ☐ Y ☐ N

Date of last prostate and rectal exam:______________________

Name (Last, First, M.I.):________________________________________ DOB ____________________

## Other Information

**Your healthcare provider needs to know:**

Do you have Advanced Directives? *(Advance Directives refer to a person's instructions about future medical care, in the event the person becomes unable to speak for himself/herself. A Living Will is an example of an Advance Directive.)*............. ☐ Y ☐ N

If no, would you like additional details about Advanced Directives? .......... ☐ Y ☐ N

Do you have any religious or cultural beliefs that may impact your healthcare? .......... ☐ Y ☐ N

If yes, please describe:________________________________________

I best learn new information by: ☐ Verbal instructions ☐ Written instructions ☐ Pictures

Level of education completed: ☐ Less than High School ☐ High School diploma or GED ☐ 1-4 years of college ☐ > 4 years of college

I understand English well? ☐ Y ☐ N If no, what language do you prefer?________________________

**In the PAST 12 MONTHS have you had any of the following symptoms?**

Frequent headaches .......... ☐ Y ☐ N
Fainting or passing out .......... ☐ Y ☐ N
Sudden loss of vision, strength or inability to speak .......... ☐ Y ☐ N
Hearing loss or ringing in ear(s) .......... ☐ Y ☐ N
Hoarseness for more than 2-4 weeks .......... ☐ Y ☐ N
Nosebleeds .......... ☐ Y ☐ N
Cough for more than 2-4 weeks .......... ☐ Y ☐ N
Coughing up blood .......... ☐ Y ☐ N
Shortness of breath or wheezing .......... ☐ Y ☐ N
Swelling in feet or ankles .......... ☐ Y ☐ N
Chest pain, chest pressure or heaviness .......... ☐ Y ☐ N
Irregular heartbeat or sudden fast heartbeat .......... ☐ Y ☐ N
Difficulty swallowing or food "sticking" .......... ☐ Y ☐ N
Frequent heartburn or indigestion .......... ☐ Y ☐ N

Abdominal pain .......... ☐ Y ☐ N
Frequent constipation .......... ☐ Y ☐ N
Frequent diarrhea .......... ☐ Y ☐ N
Rectal bleeding/black stools .......... ☐ Y ☐ N
Difficulty urinating/incontinence .......... ☐ Y ☐ N
Blood in urine .......... ☐ Y ☐ N
Urination more than twice per night .......... ☐ Y ☐ N
Pain in joints or bones .......... ☐ Y ☐ N
Unusual bruising or bleeding .......... ☐ Y ☐ N
Seizures, convulsions .......... ☐ Y ☐ N
Change in wart, mole or skin growth .......... ☐ Y ☐ N
Difficulty sleeping .......... ☐ Y ☐ N
Tearfulness .......... ☐ Y ☐ N
Difficulty concentrating .......... ☐ Y ☐ N
Weight loss more than 5-10 pounds .......... ☐ Y ☐ N

**Other symptoms:** ________________________________________

________________________________________

________________________________________

Patient's Signature:________________________________ Date:____________________

Reviewed By: ________________________________ Date:____________________

Revised 1-15-14