HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit:

___

Other concerns:

___

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1.___	___
2.___	___
3.___	___

FAVORITE PHARMACY

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.___	___	___
2.___	___	___
3.___	___	___
4.___	___	___
5.___	___	___
6.___	___	___
7.___	___	___
8.___	___	___
9.___	___	___
10.___	___	___

IMMUNIZATION HISTORY

Immunizations and most recent date:

Chickenpox	Date:___	Meningococcus	Date:___
Flu Shot	Date:___	MMR *(Measles, Mumps, Rubella)*	Date:___
Gardasil/HPV	Date:___	Pneumonia	Date:___
Hepatitis A	Date:___	Tdap *(Tetanus and pertussis)*	Date:___
Hepatitis B	Date:___	Tetanus	Date:___
		Zostavax *(Shingles)*	Date:___

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date ______________ Abnormal
Last Mammogram Date ______________ Abnormal
Age of first menstrual period: ________
Date of last menstrual period or age of menopause:
____
Number of pregnancies: ______ births: _______
miscarriages: ______ abortions: ___________
Cesarean sections If yes, then number: ______

Bleeding between periods
Heavy periods
Extreme menstrual pain
Vaginal itching, burning, or discharge
Wake in the night to go to the bathroom
Hot flashes
Breast lump or nipple discharge
Painful intercourse
Sexually active
Current sexual partner is Female Male
Do you use condoms Yes No
Other Birth control method used: ______________________
Interested in being screened for STD's

PAST MEDICAL HISTORY

Please check all that apply:

Anxiety Disorder	Diverticulitis	Kidney Disease
Arthritis	Fibromyalgia	Kidney Stones
Asthma	Gout	Leg/Foot Ulcers
Bleeding Disorder	Has Pacemaker	Liver Disease
Blood Clots (or DVT)	Heart Attack	Osteoporosis
Cancer	Heart Murmur	Polio
Coronary Artery Disease	Hiatal Hernia or Reflux Disease	Pulmonary Embolism
Claustrophobic	HIV or AIDS	Reflux or Ulcers
Diabetes - Insulin	High Cholesterol	Stroke
Diabetes - Non-Insulin	High Blood Pressure	Tuberculosis
Dialysis	Overactive Thyroid	Other

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1. ________________	________________	________________	________________
1. ________________	________________	________________	________________
3. ________________	________________	________________	________________
4. ________________	________________	________________	________________

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Grandfather (maternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic

disease
Heart disease Hypertension Osteoporosis Stroke

Grandmother (paternal) Y/N ______ Alcoholism Arthritis Depression Cancer Diabetes Genetic disease
Heart disease Hypertension Osteoporosis Stroke

Grandfather (paternal) Y/N ______ Alcoholism Arthritis Depression Cancer Diabetes Genetic disease
Heart disease Hypertension Osteoporosis Stroke

Father Y/N ______ Alcoholism Arthritis Depression Cancer Diabetes Genetic disease
Heart disease Hypertension Osteoporosis Stroke

Mother Y/N ______ Alcoholism Arthritis Depression Cancer Diabetes Genetic disease
Heart disease Hypertension Osteoporosis Stroke

Brother/Sister Y/N ______ Alcoholism Arthritis Depression Cancer Diabetes Genetic disease
Heart disease Hypertension Osteoporosis Stroke

Brother/Sister Y/N ______ Alcoholism Arthritis Depression Cancer Diabetes Genetic disease
Heart disease Hypertension Osteoporosis Stroke

Other:______ Y/N ______ Alcoholism Arthritis Depression Cancer Diabetes Genetic disease
Heart disease Hypertension Osteoporosis Stroke

SOCIAL HISTORY

Education Less than 8th grade
High school
2 year college 4 year college
Post graduate

Marital Status Married
Single
Divorced Separated
Widowed
Domestic partner

Exercise Level None (No exercise)
Occasional exercise
Moderate exercise
High level exercise

Caffeine None
Occasional
Moderate Heavy
# of cups/cans per day?
____

Alcohol Do you drink alcohol?
Yes No
If so, how often?
Occasionally < 3 times a week
> 3 times a week
How many drinks per week? __

Tobacco Do you use tobacco?
Yes No

If not currently, did you ever use tobacco? Yes No
Cigarettes -____pks./day
Chew - ____/day
Cigars - _____/day
# of years____
Or year quit __________

Drugs Do you currently use recreational or street drugs? Yes No
If yes, list:
____
____

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic

Ears/Nose/Mouth/Throat
Bleeding Gums
Difficulty Hearing

Genitourinary
Blood in Urine
Difficulty Urinating

Neurological
Dizziness
Fainting

Frequent Sneezing
Hives
Itching
Runny Nose
Sinus Pressure

Cardiovascular

Arm Pain on Exertion
Chest Pain on Exertion
Chest Heaviness/Pressure on Exertion
Irregular Heart Beats (Palpitations)
Known Heart Murmur
Light-headed on Standing
Shortness of Breath When Lying Down
Shortness of Breath When Walking
Swelling (edema)

Constitutional

Exercise Intolerance
Fatigue
Fever
Weight Gain (____lbs)
Weight Loss (____lbs)

Eyes

Dry Eyes
Irritation
Vision Change
Date of Last Exam:________

Dizziness
Dry Mouth
Ear Pain
Frequent Infections
Frequent Nosebleeds
Hoarseness
Mouth Breathing
Mouth Ulcers
Nose/Sinus Problems
Ringing in Ears

Endocrine

Fatigue
Increased Thirst/Hunger/Urination

Gastrointestinal

Abdominal Pain
Black or Tarry Stool
Blood in Stool
Change in Appetite
Frequent Indigestion
Hemorrhoids
Trouble Swallowing
Vomiting
Vomiting Blood

Incomplete Emptying
Increased Urinary Frequency
Urinary Loss of Control

Hematologic/Lymphatic

Easy Bruising/Bleeding
Swollen Glands

Integumentary (Skin)

Changes in Moles
Dry Skin
Eczema
Growth/Lesions
Itching
Jaundice (Yellow Skin/Eyes)
Rash

Musculoskeletal

Back Pain
Joint Pain
Muscle Aches
Muscle Weakness

Headaches
Memory Loss
Migraines
Numbness
Restless Legs
Seizures
Weakness

Psychiatric

Alcohol Overuse
Anxiety/Stress
Depression
Do Not Feel Safe in Relationship
Mania
Sleep Problems

Respiratory

Cough
Coughing Up Blood
Shortness of Breath
Sleep Apnea
Snoring
Wheezing

Please add any other information about your health that you would like your provider to know here:

Parent, Guardian, or Caregiver Signature ____________________

Date ____________________