

Original Date: ___/___/___
 Dates Revised: ___/___/___
 ___/___/___
 ___/___/___

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: _____ M F DOB ___/___/___
(Last, First, M.I.)

Marital Status: Single Partnered Married Separated Divorced Widowed

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

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries:	Year	Reason	Hospital

Other Hospitalizations:	Year	Reason	Hospital

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

Please turn to next page

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

HEALTH HABITS AND PERSONAL SAFETY

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 min.)

Diet: Are you dieting? Yes No
 If yes, are you on a physician prescribed medical diet?..... Yes No
 # of meals you eat in an average day? _____
 Rank Salt Intake High Med Low Rank Fat Intake High Med Low

Caffeine: None Coffee Tea Cola # of Cups/Cans Per Day? _____

All questions contained in this questionnaire are optional and will be kept strictly confidential.

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 experience 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 _____ and/or Year Quit _____

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Drugs: Do you currently use recreational or street drugs? Yes No
 Have you ever given yourself street drugs with a needle? Yes No

All questions contained in this questionnaire are optional and will be kept strictly confidential.

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

Please turn to next page

Personal Safety:

- Do you live alone? Yes No
- Do you have frequent falls? Yes No
- Do you have vision or hearing loss? Yes No
- Do you have an Advance Directive and/or Living Will? Yes No
- Would you like information on the preparation of these? Yes No

Physical and mental abuse has 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

Please remember that the following recommendations are very important to maintaining your health.

When in a car, wear your safety belt at all times.

While riding a motorcycle or bicycle, wear a helmet.

Always have functional smoke detectors and fire extinguishers in your home.

If you own a firearm, make sure that it is accessible only to you. Take every precaution to ensure that children do not have access to a loaded firearm.

Keep the firearm and ammunition in separate locations.

FAMILY HEALTH HISTORY

	Age	Age at Death	Significant Health Problems or Cause of Death		Age	Age at Death	Significant Health Problems or Cause of Death
Father				Children	<input type="checkbox"/> M <input type="checkbox"/> F		
Mother					<input type="checkbox"/> M <input type="checkbox"/> F		
Brothers and Sisters	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandparents (Mother's Side)			
	<input type="checkbox"/> M <input type="checkbox"/> F			Male			
	<input type="checkbox"/> M <input type="checkbox"/> F			Female			
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandparents (Father's Side)			
	<input type="checkbox"/> M <input type="checkbox"/> F			Male			
	<input type="checkbox"/> M <input type="checkbox"/> F			Female			

Please turn to next page

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have problems with eating or your appetite?	<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 about hurting yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes <input type="checkbox"/> No

WOMEN ONLY

Age at onset of menstruation: ____ Date of last menstruation: ____/____/____	
Period every ____ days. Heavy periods, irregularity, spotting, pain or discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____	
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a D&C, hysterectomy or cesarean?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any urinary tract, bladder or kidney infections within the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any blood in urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around time of period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Experienced any recent breast tenderness, lumps or nipple discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last pap and rectal exam? ____/____/____	

MEN ONLY

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

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin _____ <input type="checkbox"/> Head/Neck _____ <input type="checkbox"/> Ears _____ <input type="checkbox"/> Nose _____ <input type="checkbox"/> Throat _____ <input type="checkbox"/> Lungs _____ <input type="checkbox"/> Chest/Heart _____	<input type="checkbox"/> Back _____ <input type="checkbox"/> Intestinal _____ <input type="checkbox"/> Bladder _____ <input type="checkbox"/> Bowel _____ <input type="checkbox"/> Circulation _____ Recent Changes In <input type="checkbox"/> Weight _____	<input type="checkbox"/> Energy Level _____ <input type="checkbox"/> Ability to Sleep _____ Other Pain/Discomfort: _____ _____ _____
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