



HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help us 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 THE 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. _____	_____

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:

- | | | | |
|---------------------------------------|-------------|--|-------------|
| <input type="checkbox"/> Chickenpox | Date: _____ | <input type="checkbox"/> Meningococcus | Date: _____ |
| <input type="checkbox"/> Flu Shot | Date: _____ | <input type="checkbox"/> MMR (Measles, Mumps, Rubella) | Date: _____ |
| <input type="checkbox"/> Gardasil/HPV | Date: _____ | <input type="checkbox"/> Pneumonia | Date: _____ |
| <input type="checkbox"/> Hepatitis A | Date: _____ | <input type="checkbox"/> Tdap (Tetanus and pertussis) | Date: _____ |
| <input type="checkbox"/> Hepatitis B | Date: _____ | <input type="checkbox"/> Tetanus | Date: _____ |
| | | <input type="checkbox"/> Zostavax (Shingles) | Date: _____ |

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

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y / N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Grandfather (maternal)	Y / N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Grandmother (paternal)	Y / N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Grandfather (paternal)	Y / N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Father	Y / N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Mother	Y / N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Brother/Sister	Y / N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Brother/Sister	Y / N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Other	Y / N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> 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?

- No
 Cigarettes
Chew ____ / day
 Cigars _____
 # 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

- 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)

- Dry Eyes
- Irritation
- Vision Change
- Date of last exam: _____

Ears/Nose/Mouth/Throat

- Bleeding Gums
- Difficulty Hearing
- 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

Genitourinary

- Blood in Urine
- Difficulty Urinating
- Incomplete Urinary Emptying
- 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

Neurological

- Dizziness
- Fainting
- 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