

**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. _____	_____

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**FAVORITE PHARMACY**

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**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. _____	_____	_____

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**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 ( <i>Measles, Mumps, Rubella</i> )	Date: _____
<input type="checkbox"/> Gardasil/HPV	Date: _____	<input type="checkbox"/> Pneumonia	Date: _____
<input type="checkbox"/> Hepatitis A	Date: _____	<input type="checkbox"/> Tdap ( <i>Tetanus and pertussis</i> )	Date: _____
<input type="checkbox"/> Hepatitis B	Date: _____	<input type="checkbox"/> Tetanus	Date: _____
		<input type="checkbox"/> Zostavax ( <i>Shingles</i> )	Date: _____

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**(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY**

Last PAP Smear Date _____	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Bleeding between periods
Last Mammogram Date _____	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Heavy periods
Age of first menstrual period: _____		<input type="checkbox"/> Extreme menstrual pain
Date of last menstrual period or age of menopause: _____		<input type="checkbox"/> Vaginal itching, burning, or discharge
Number of pregnancies: _____ births: _____		<input type="checkbox"/> Wake in the night to go to the bathroom
miscarriages: _____ abortions: _____		<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Cesarean sections If yes, then number: _____		<input type="checkbox"/> Breast lump or nipple discharge
		<input type="checkbox"/> Painful intercourse
		<input type="checkbox"/> Sexually active
		Current sexual partner is <input type="checkbox"/> Female <input type="checkbox"/> Male
		Do you use condoms <input type="checkbox"/> Yes <input type="checkbox"/> No
		Other Birth control method used: _____
		<input type="checkbox"/> Interested in being screened for STDs

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**PAST MEDICAL HISTORY**

Please check all that apply:

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

**PAST SURGICAL HISTORY**

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

**FAMILY HEALTH HISTORY**

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Grandmother</b> (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
<b>Grandfather</b> (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
<b>Grandmother</b> (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
<b>Grandfather</b> (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
<b>Father</b>	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
<b>Mother</b>	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
<b>Brother/Sister</b>	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
<b>Brother/Sister</b>	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
<b>Other:</b> _____	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**

<p><b>Education</b>   <input type="checkbox"/> Less than 8th grade</p> <p><input type="checkbox"/> High school</p> <p><input type="checkbox"/> 2 year college   <input type="checkbox"/> 4 year college</p> <p><input type="checkbox"/> Post graduate</p>	<p><b>Caffeine</b>   <input type="checkbox"/> None   <input type="checkbox"/> Occasional</p> <p><input type="checkbox"/> Moderate   <input type="checkbox"/> Heavy</p> <p># of cups/cans per day? _____</p>	<p>If not currently, did you ever use tobacco?   <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p><input type="checkbox"/> Cigarettes - _____pks./day</p> <p><input type="checkbox"/> Chew - _____/day</p> <p><input type="checkbox"/> Cigars - _____/day</p> <p><input type="checkbox"/> # of years _____</p> <p>Or year quit _____</p>
<p><b>Marital Status</b>   <input type="checkbox"/> Married   <input type="checkbox"/> Single</p> <p><input type="checkbox"/> Divorced   <input type="checkbox"/> Separated   <input type="checkbox"/> Widowed</p> <p><input type="checkbox"/> Domestic partner</p>	<p><b>Alcohol</b>   Do you drink alcohol?</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>If so, how often?</p> <p><input type="checkbox"/> Occasionally   <input type="checkbox"/> &lt; 3 times a week</p> <p><input type="checkbox"/> &gt; 3 times a week</p> <p>How many drinks per week? _____</p>	<p><b>Drugs</b>   Do you currently use recreational or street drugs?   <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>If yes, list:</p> <p>_____</p> <p>_____</p>
<p><b>Exercise Level</b>   <input type="checkbox"/> None (No exercise)</p> <p><input type="checkbox"/> Occasional exercise</p> <p><input type="checkbox"/> Moderate exercise</p> <p><input type="checkbox"/> High level exercise</p>	<p><b>Tobacco</b>   Do you use tobacco?</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p>	

**REVIEW OF SYSTEMS**

<p><b>Please check all that apply:</b></p> <p><b>Allergic/Immunologic</b></p> <p><input type="checkbox"/> Frequent Sneezing</p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Runny Nose</p> <p><input type="checkbox"/> Sinus Pressure</p> <p><b>Cardiovascular</b></p> <p><input type="checkbox"/> Arm Pain on Exertion</p> <p><input type="checkbox"/> Chest Pain on Exertion</p> <p><input type="checkbox"/> Chest Heaviness/Pressure on Exertion</p> <p><input type="checkbox"/> Irregular Heart Beats (Palpitations)</p> <p><input type="checkbox"/> Known Heart Murmur</p> <p><input type="checkbox"/> Light-headed on Standing</p> <p><input type="checkbox"/> Shortness of Breath When Lying Down</p> <p><input type="checkbox"/> Shortness of Breath When Walking</p> <p><input type="checkbox"/> Swelling (edema)</p> <p><b>Constitutional</b></p> <p><input type="checkbox"/> Exercise Intolerance</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Weight Gain (___ lbs)</p> <p><input type="checkbox"/> Weight Loss (___ lbs)</p> <p><b>Eyes</b></p> <p><input type="checkbox"/> Dry Eyes</p> <p><input type="checkbox"/> Irritation</p> <p><input type="checkbox"/> Vision Change</p> <p>Date of Last Exam: _____</p>	<p><b>Ears/Nose/Mouth/Throat</b></p> <p><input type="checkbox"/> Bleeding Gums</p> <p><input type="checkbox"/> Difficulty Hearing</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Dry Mouth</p> <p><input type="checkbox"/> Ear Pain</p> <p><input type="checkbox"/> Frequent Infections</p> <p><input type="checkbox"/> Frequent Nosebleeds</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Mouth Breathing</p> <p><input type="checkbox"/> Mouth Ulcers</p> <p><input type="checkbox"/> Nose/Sinus Problems</p> <p><input type="checkbox"/> Ringing in Ears</p> <p><b>Endocrine</b></p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Increased Thirst/Hunger/Urination</p> <p><b>Gastrointestinal</b></p> <p><input type="checkbox"/> Abdominal Pain</p> <p><input type="checkbox"/> Black or Tarry Stool</p> <p><input type="checkbox"/> Blood in Stool</p> <p><input type="checkbox"/> Change in Appetite</p> <p><input type="checkbox"/> Frequent Indigestion</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Trouble Swallowing</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Vomiting Blood</p>	<p><b>Genitourinary</b></p> <p><input type="checkbox"/> Blood in Urine</p> <p><input type="checkbox"/> Difficulty Urinating</p> <p><input type="checkbox"/> Incomplete Emptying</p> <p><input type="checkbox"/> Increased Urinary Frequency</p> <p><input type="checkbox"/> Urinary Loss of Control</p> <p><b>Hematologic/Lymphatic</b></p> <p><input type="checkbox"/> Easy Bruising/Bleeding</p> <p><input type="checkbox"/> Swollen Glands</p> <p><b>Integumentary (Skin)</b></p> <p><input type="checkbox"/> Changes in Moles</p> <p><input type="checkbox"/> Dry Skin</p> <p><input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> Growth/Lesions</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Jaundice (Yellow Skin/Eyes)</p> <p><input type="checkbox"/> Rash</p> <p><b>Musculoskeletal</b></p> <p><input type="checkbox"/> Back Pain</p> <p><input type="checkbox"/> Joint Pain</p> <p><input type="checkbox"/> Muscle Aches</p> <p><input type="checkbox"/> Muscle Weakness</p>	<p><b>Neurological</b></p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Memory Loss</p> <p><input type="checkbox"/> Migraines</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Restless Legs</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Weakness</p> <p><b>Psychiatric</b></p> <p><input type="checkbox"/> Alcohol Overuse</p> <p><input type="checkbox"/> Anxiety/Stress</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Do Not Feel Safe in Relationship</p> <p><input type="checkbox"/> Mania</p> <p><input type="checkbox"/> Sleep Problems</p> <p><b>Respiratory</b></p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Coughing Up Blood</p> <p><input type="checkbox"/> Shortness of Breath</p> <p><input type="checkbox"/> Sleep Apnea</p> <p><input type="checkbox"/> Snoring</p> <p><input type="checkbox"/> Wheezing</p>
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Please add any other information about your health that you would like your provider to know here:

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\_\_\_\_\_  
Patient, Parent, Guardian, or Caregiver Signature

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Date