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Name

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DOB**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                          |
-

Name \_\_\_\_\_

DOB \_\_\_\_\_

### 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

**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:

\_\_\_\_\_  
 \_\_\_\_\_

Name

DOB

# 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:

Patient, Parent, Guardian, or Caregiver Signature

Date