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:
____

Current Height and Weight:
____

ALLERGIES

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

ALLERGY	REACTION
1.______________________________	______________________________
2.______________________________	______________________________
3.______________________________	______________________________

PHARMACY

LOCAL PHARMACY: ____

MAIL ORDER PHARMACY (IF APPLICABLE): ______________________________

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.____________________	____________________	____________________

PAST SURGICAL HISTORY

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

IMMUNIZATION HISTORY

Immunizations and most recent date:

Chickenpox	Date:____________	MMR *(Measles, Mumps, Rubella)*	Date:____________
Flu Shot	Date:____________	Pneumovax 23 *(penumonia)*	Date:____________
Gardasil/HPV	Date:____________	Prevnar 13 *(pneumonia)*	Date:____________
Hepatitis A	Date:____________	Tdap *(Tetanus and pertussis)*	Date:____________
Hepatitis B	Date:____________	Tetanus	Date:____________
Meningococcus	Date:____________	Zostavax *(Shingles)*	Date:____________

PAST MEDICAL HISTORY

Please circle ALL that apply:

Acne
ADD/ADHD
Allergic Rhinitis
Anxiety Disorder
Arthritis
Asthma
Bleeding Disorder
Blood Clots or (DVT)
Cancer
Chronic Back Pain
Chronic Pain
Claustrophobic
Clostridium Difficile (C.Diff) Colitis
Coronary Artery Disease
Depression
Diabetes - Insulin
Diabetes - Non-Insulin
Dialysis
Diverticulitis/Diverticulosis
Fibromyalgia
Frequent Skin Sores
GERD (Acid Reflux Disorder)
Gout
Has Pacemaker
Heart Attack
Heart Murmur
Hemorrhoids
Hiatal Hernia or Reflux Disease
High Blood Pressure
High Cholesterol
History of Suicide Attempt
HIV or AIDS
Joint Pain
Kidney Disease
Kidney Stones
Leg/Foot Ulcers
Liver Disease
MRSA/Other Resistant bacterial Infection
Osteoporosis
Pancreatitis
Peripheral Edema/Swelling
Polio
PUD (Peptic Ulcer Disorder)
Pulmonary Embolism
Reflux or Ulcers
Stroke
Testicular Problem
Thyroid Disorders
Tuberculosis
Warts

Please circle the condition that applies:

Headaches:
- Headaches
- Migraines
- Tension
- Cluster

Endocrine Disorders:
- Hypogonadism
- Adrenal Problems
- Other:

GYN Problems:
- Endometriosis
- Fibroids
- Ovarian Cysts

Sleep Disorders:
- Obstructive Sleep Apnea
- Insomnia
- Other:

Vision/Eye Disorders:
- Glaucoma
- Low Visual Acuity
- Other

Intestinal Disorders:
- IBS
- IBD (Crohns/Ulcerative Colitis)
- Other:

Sexually Transmitted Diseases:
- Chlamydia
- Gonorrhea
- Genital Herpes
- Genital Warts
- Syphilis
- Other:

COPD:
- Chronic Bronchitis
- Emphysema

Prostate Problems:
- Benign Prostate
- Enlargement
- Prostate Cancer

Circulatory Issues:
Venous Insufficiency
Arterial Insufficiency

Liver Disease:
Hepatitis A
Hepatitis B
Hepatitis C

Patient Name: ______________________________

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Have you EVER had an abnormal PAP or Mammogram? *Please specify and provide dates:*
____

Last PAP Smear
Date ________________ Abnormal Y/N
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: Y/N If yes, then number: ______

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

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

Please list any other Physicians or Medical Specialists that you currently use, as well as the medical issues they are managing for you:
____
____

If you have ever had any of the following, please note the dates and results, if possible:
Colonoscopy: ____
DEXA/Bone Density Scan: ____

Please note any test, with dates and results, you may have had in the past that you feel are currently relevant, including X-rays, MRI/A, CT, Ultrasounds, Nuclear medicine Scans, Biopsies, Endoscopy, Cystoscopy, Colposcopy, Stress Tests, Sleep Studies, Cardiac Catheterizations, etc.
____
____
____

Patient Name: ____

SOCIAL HISTORY

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

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

Tobacco
Current smoker? Y/N
Cigarettes: ____ pks./day
Chew: ____ /day
Cigars: ____/day
# of years: ______
Former smoker? Y/N
Year quit _____

Marital Status
Married
Single
Divorced
Separated
Widowed
Domestic Partner

Alcohol
Do you drink alcohol? Y/N
If so, how often?
Occasionally
< 3 times/week
>3 times/week
Drinks per week ____

Drugs
Do you use recreational or street drugs? Y/N
If yes, list:
____
__

Have you used recreational or street drugs in the past? Y/N
If yes, list:
____
__

Exercise Level
None
Occasional
Moderate
High

Name:

DOB:

Age:

Address:

Phone Number:

Insurance Provider & Member ID:

Occupation:

Religious Affiliation:

Interests/Hobbies:

Do we see any other family members?

Name and ages of children, if any:

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

Patient, Guardian, or Caregiver Signature

Date