Dr. Benjamin Lee
INTERNAL MEDICINE

Health History Questionnaire

Your answers to these questions help your healthcare provider better understand your medical concerns and conditions. If you are uncomfortable with any question, you are **not** required to answer it.

Reason for visit:

_____

Pharmacy Information:

Local Pharmacy: _____

Pharmacy Street Address	**City**	**State**	**Zip Code**
( )	**( )**		
Phone Number	**Fax Number**		

Mail Order Pharmacy: _____

Pharmacy Street Address	**City**	**State**	**Zip Code**
( )	**( )**		
Phone Number	**Fax Number**		

Allergies/Adverse Reactions:

Please list any allergies to **MEDICATIONS** below along with their reaction and the severity if the reaction:

Allergy:	Reaction:	Severity (circle one):
1._____	1._____	Mild Moderate Severe
2._____	2._____	Mild Moderate Severe
3._____	3._____	Mild Moderate Severe
4. _____	4. _____	Mild Moderate Severe
5._____	5. _____	Mild Moderate Severe

Do you have any **seasonal** or **environmental allergies?** (circle one): YES NO
If yes, please list: _____
_____

Medications:

Please list **ALL** medications you are taking, including all prescription medications, over the counter medications, vitamins, supplements, herbals, inhalers, etc).

Medication Name	Strength	Frequency

Immunizations:

Influenza: Date: _____ Where: _____

Pneumococcal Pneumonia:

Pneumovax 23: Date: _____ Where: _____
Prevnar 13: Date: _____ Where: _____
Prevnar 20: Date: _____ Where: _____

Shingrix:

Dose #1: Date: _____ Where: _____
Dose #2: Date: _____ Where: _____

Tdap (tetanus, diptheria and pertussis): Date: _____ Where: _____

TD(just tetanus, diptheria): Date: _____ Where: _____

HPV:

Dose #1: Date: _____ Where: _____
Dose #2: Date: _____ Where: _____
Dose #3: Date: _____ Where: _____

Most recent COVID booster: Date: _____ Where: _____

RSV: Date: _____ Where: _____

Specialists:

Please list the name of any of the following Providers/Specialists that you see currently or have seen in the past:

1. **Previous Primary Care Provider (PCP): _____**
2. **Cardiologist (Heart Doctor): _____**
3. **Pulmonologist (Lung Doctor): _____**
4. **Gastroenterologist (Stomach/Intestinal Doctor): _____**
5. **Pain Management: _____**
6. **Ophthalmologist (Eye Doctor): _____**
7. **Psychiatrist: _____**
8. **OB/GYN (Female Doctor): _____**
9. **Other: _____**

Family History:

Please indicate if there is any family history of any of the below issues. Be sure to indicate which family member (Mother/Father, Grandmother/grandfather, etc). For all members outside of Mother, Father, siblings and children, please indicate if they are **MATERNAL** or **PATERNAL** relations.

Cancer (if yes, please indicate TYPE): _____

Heart Disease: _____

Heart Attack: _____

High Blood Pressure:_____

Stroke: _____

Diabetes: _____

Genetic Disease: _____

High Cholesterol: _____

Depression/Anxiety: _____

Arthritis: _____

Osteoporosis: _____

Substance Abuse (Drugs/Alcohol): _____

Social History:

Education:

1. **What is the highest level of education you have completed? ☐ High School/GED ☐ Some College, no degree ☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Professional Degree (MD, DDS, DVM, JD) ☐ Doctoral Degree (PhD, EdD)**

Tobacco Use:

1. **Smoking Status: ☐ Never Smoker ☐ Former Smoker ☐ Current Everyday Smoker ☐ Current Some Days Smoker**
   If you are smoker or former smoker:
   -Age you started smoking: _____
   -Age you quit smoking: _____

How much tobacco do/did you smoke: ☐ 1 pack/week ☐ 2 packs/week ☐ ¼ pack/day ☐ ½ pack/day ☐ 1 pack/day ☐ 2 packs/day ☐ 3 packs/day

Do you use any other forms of tobacco? (please circle): YES NO
If yes, what type: ☐ E-Cigarette/Vape ☐ Smokeless Tobacco (chew, dip/snuff) ☐ Cigars

Substance Use:

1. **What is your level of alcohol consumption? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy**
2. **Do you use any illicit or recreational drugs? (please circle): YES NO**
   If yes, what type: _____
3. **What is your level of caffeine consumption? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy**
   If yes, what type and how much: _____

Diet and Exercise:

1. **What type of diet are you following? ☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Cardiac ☐ Diabetic ☐ Other, please specify: _____**
2. **What is your exercise level? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy**
3. **How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? _____**
4. **Do you participate in any sporting activities? (please circle): YES NO**
   If yes, which activities? _____

Sexual History:

1. **Are you sexually active? (please circle): YES NO**
2. **Current sexual partner: ☐ Male ☐ Female ☐ Other**
3. **Do you or your partner use contraception? (ex: condoms, birth control, etc)**
   (please circle): YES NO
   If yes, what kind:_____
4. **Are you interested in being screened for sexually transmitted infections?**
   (please circle): YES NO

Advanced Directives:

1. **Do you have an Advanced Directive? ☐ Yes ☐No**
2. **Do you have a Medical Power of Attorney? ☐ Yes ☐ No**
   If yes, who? _____
   Phone number: _____

*****IF YOU HAVE ANSWERED YES TO EITHER OF THE ABOVE QUESTIONS, PLEASE BE SURE TO PROVIDE US A COPY FOR YOUR RECORD OF THOSE DOCUMENTS*****

Surgical History:

1. **Do you have any reaction to anesthesia? (please circle): YES NO**
   If yes, what is the reaction: _____
2. **When was your last colonoscopy? Date: _____ Location: _____**

Surgery:	Approximate Date:	Where:

Obstetric and Gynecological History:

WOMEN ONLY

1. **Age of first Menstrual Period: _____**
2. **Date of last period, or age of menopause: _____**
3. **Number of pregnancies: _____ Number of Births: _____ Number of Miscarriages: _____ Number of Abortions: _____**
4. **Have you ever had a Cesarean Section? (please circle): YES NO**
   If yes, how many? _____
5. **Last PAP smear: Date: _____ Where: _____**
6. **Last Mammogram: Date: _____ Where: _____**
7. **Please CHECK below if you experience any of the following:**
   ☐ Bleeding between periods ☐ Heavy periods ☐ Extreme menstrual pain
   ☐ Vaginal itching, burning, or discharge ☐ Waking in the night to use bathroom.
   ☐ Hot flashes ☐ Breast lump or nipple discharge ☐ Painful intercourse

Past Medical Problems:

Please check all that apply

Anxiety	
Anemia	
Arthritis	
Asthma/COPD	
Bleeding Disorder	
Blood Clots (DVT or Pulmonary Embolism)	
Cancer **(What kind? _____)**	
Coronary Artery Disease	
Claustrophobic	
Diabetes – Insulin Dependent	
Diabetes – Non-insulin dependent	
Depression	
Diverticulosis	
Fibromyalgia	
Gout	
Pacemaker	
Heart Attack	
Heart Murmur	
Hiatal Hernia	
GERD/Acid Reflux	
HIV/AIDs	
High Cholesterol	
High Blood Pressure	
Irritable Bowel Syndrome (IBS)	
Kidney Disease	
Kidney Stones	
Leg/Foot Ulcers	
Liver Disease	
Lyme Disease	
Migraines	
Osteopenia/Osteoporosis	
Seizures	
Sleep Apnea	
Stroke	
Thyroid Problems	
Urinary Tract Infection	
Other past issues (please list below):	

Current Symptoms & Complaints

Please CIRCLE all that apply to you:

Constitutional • Exercise Intolerance • Fever/ Chills • Weight Gain (____lbs) • Weight Loss (____lbs)	**Genitourinary** • Blood in Urine • Burning with Urination • Incomplete Emptying • Increased Frequency • Urinary Loss of Control (leaking)	**Psychiatric** • Anxiety/Stress • Depression • Feel unsafe in relationship • Sleep Difficulties
Cardiovascular • Chest Pain on Exertion • Shortness of Breath with Exertion • Chest Heaviness/Pressure • Irregular Heart Beat/Palpitations • Known Heart Murmur • Lightheadness/Dizziness • Swelling legs	**Gastrointestinal** • Abdominal Pain • Black or Dark Stool • Blood in Stool • Change in Appetite • Heartburn • Hemorrhoids • Difficulty Swallowing • Nausea • Vomiting	**Eyes** • Dry Eyes • Vision Changes **Ears** • Difficulty Hearing • Ringing of the Ears **Nose** • Nosebleeds **Mouth** • Hoarseness • Bleeding Gums • Dry Mouth • Mouth Ulcers • Tooth Pain
Allergic/Immunologic • Frequent Sneezing • Hives • Itching • Runny Nose • Sinus Pressure	**Musculoskeletal** • Back Pain • Joint Pain • Muscle Aches • Muscle Weakness • Difficulty with Walking • History of fall in the last year	**Endocrine** • Fatigue • Increased Hunger • Increased Thirst • Increased Urination • Dry Skin • Thinning Hair
Respiratory • Cough • Shortness of breath • Snoring • Wheezing	**Neurological** • Fainting • Headaches • Memory Loss • Restless Legs • Weakness • Numbness/Tingling in Extremities	**Skin** • Changes in Moles • Eczema • Rash

Please list any additional information about your health that you would like your provider to aware of:

_____

_____

_____