

**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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**OBSTETRIC AND GYNECOLOGICAL HISTORY**

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

**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**

<b>SURGERY</b>	<b>REASON</b>	<b>YEAR</b>	<b>HOSPITAL</b>
1. _____	_____	_____	_____
1. _____	_____	_____	_____
3. _____	_____	_____	_____
4. Colonoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____

**FAMILY HEALTH HISTORY**

<b>RELATION</b>	<b>ALIVE?</b>	<b>AGE</b>	<b>SIGNIFICANT HEALTH PROBLEMS</b>
<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:**

- 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:**

## REVIEW OF SYSTEMS

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