

Name _____

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. _____	_____

FAVORITE PHARMACY

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. _____	_____	_____

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

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

Painful intercourse

Sexually active

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

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

FAMILY HEALTH HISTORY

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