HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. Please answer to the best of your knowledge as these questions will assist us in your individualized comprehensive medical care.

Name *(Last, First, M.I.)*: ☐Male ☐Female ☐Other:	Date of Birth:
Previous or referring physician: *Please include name, address, & phone number*	Date of last physical exam:

IMMUNIZATIONS *(please include date given)*

☐Tetanus (Tdap/Td)	☐Varicella	☐Hepatitis B	☐ Hepatitis A
☐MMR	☐Pneumonia	☐Shingles	☐ Other:

CHILDHOOD ILLNESSES: ☐Measles ☐Mumps ☐Rubella ☐Chickenpox ☐Polio ☐Other:

CURRENT CHRONIC MEDICAL CONDITIONS *(circle all that apply)* ☐ None

AID/HIV	Coronary Artery Disease	Osteoporosis
Anemia	Depression	Prostate Problems
Anxiety	Diabetes	Renal Disease
Arthritis	Drug Dependency	Seasonal Allergies
Asthma	Gout	Sleep Apnea
Atrial Fibrillation	GERD	Thyroid Disease
Cancer *(please specify)*:	Hepatitis C	Other Illnesses:
	Hyperlipidemia/High Cholesterol	
Cerebrovascular Accident/Stroke	Hypertension/High Blood Pressure	
Congestive Heart Failure	Kidney Disease	
COPD	Multiple Sclerosis	

ALLERGIES: *Please list food & drug allergies* ☐ Unknown

Name & Reaction	Name & Reaction

CURRENT MEDICATIONS: *Please list prescribed & over-the-counter drugs being taken* ☐ None

Name & Dosage	Frequency Taken	Name & Dosage	Frequency Taken

PHARMACY:

DIAGNOSTIC STUDIES: *(please include dates)* ☐ None

☐ Colonoscopy	☐ Upper Endoscopy	☐ Mammogram
☐ Bone Density Scan	☐Pap Smear	☐ Other:

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SURGERIES & OTHER HOSPITALIZATIONS ☐ None

Year	Reason/Procedure	Hospital

SOCIAL HISTORY

Travel	Have you travelled within the past 30 days? ☐Yes ☐No If yes, where did you go?
	Have you developed any of these symptoms within the past 30 days? ☐None ☐Fever ☐Rash ☐Diarrhea ☐Body aches ☐Other:
Mood	Over the past two weeks have you been bothered by any of the following problems?
	Little interest or pleasure in doing things? ☐Yes ☐No
	Feeling down, depressed or hopeless? ☐Yes ☐No
Alcohol	Do you drink alcohol? ☐Yes ☐Former ☐Never Former user – Quit date:
	If yes, what kind? ☐Beer ☐Wine ☐Hard Liquor How many drinks per week?
Tobacco	Do you use tobacco? ☐Yes ☐Former ☐Never Former user – Quit date:
	If yes, what kind? ☐Cigarettes ☐Cigars ☐Chew ☐Pipe ☐Snuff ☐Vape
	Packs/day? ☐0.25 ☐0.50 ☐0.75 ☐1 ☐>1 Years used: Are you ready to quit? ☐Yes ☐No
Substance	Do you use drugs? ☐Yes ☐Not Currently ☐Never
	If yes, what kind? ☐Cocaine ☐Codeine ☐Heroine ☐Hydrocodone ☐LSD ☐Marijuana ☐Other:
	Uses/week?
Sex	Are you sexually active? ☐Yes ☐No If yes, are you trying for a pregnancy? ☐Yes ☐No
	If not trying for a pregnancy list contraceptive or barrier method used: ☐Condoms ☐Contraceptive Pill ☐IUD ☐Other:
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? ☐Yes ☐No
Safety	*Physical and/or mental abuse have also become a major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse.* Would you like to discuss this issue with your provider? ☐Yes ☐No

FAMILY HEALTH HISTORY ☐ Adopted ☐ Family History Unknown

Father:	☐Cholesterol ☐Blood Pressure ☐Diabetes ☐Cancer ☐Other:	Paternal Grandmother:	☐Cholesterol ☐Blood Pressure ☐Diabetes ☐Other:
		Paternal Grandfather:	☐Cholesterol ☐Blood Pressure ☐Diabetes ☐Other:
Mother:	☐Cholesterol ☐Blood Pressure ☐Diabetes ☐Cancer ☐Other:	Maternal Grandmother:	☐Cholesterol ☐Blood Pressure ☐Diabetes ☐Other:
		Maternal Grandfather:	☐Cholesterol ☐Blood Pressure ☐Diabetes ☐Other:
Sibling(s) / Other relative(s):			