HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: (Last, First, M.I.) ☐**Male** ☐**Female** **Date of Birth:**

Marital Status: ☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed
Occupation: _____

Previous or Other Health Care Providers:

PERSONAL HEALTH HISTORY

Childhood Illness: ☐Measles ☐Mumps ☐Rubella ☐Chicken Pox ☐Rheumatic Fever ☐Polio ☐Other

Immunizations And Dates: ☐Hepatitis A ☐Hepatitis B ☐ MMR (Measles Mumps Rubella) ☐Chicken Pox ☐Influenza ☐ Pneumonia ☐Tetanus ☐Other

List any Medical Conditions/Illnesses:

List any Hospital Admissions:

Have you ever had a blood transfusion? ☐Yes ☐No **If yes, what year?**

List your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Name of Drug	Strength	Frequency Taken

Allergies to Medications:

Name of Drug	Reaction You Had

FAMILY HEALTH HISTORY

List any Family Medical Conditions/Illnesses:

Do you or a blood relative have, or have had, any symptoms in the following areas to a significant degree -- briefly explain below.

□ Skin	□ Lungs		**Other Pain/Discomfort:**
□ Head/Neck	□ Back	**Recent Changes in:**	
□ Ears	□ Intestines/Bowels	□ Weight	
□Eyes	□ Circulation	□ Energy Level	
□ Nose	□ Bladder	□ Ability to Sleep	
□ Throat	□Bones,Muscles, Joints, etc.		

Explanation:

HEALTH HABITS AND PERSONAL SAFETY

Exercise: □**Sedentary (No Exercise)** □ **Mild Exercise (i.e. climb stairs, walk 3 blocks, golf)**
□**Occasional Vigorous Exercise (i.e. work or recreation less than 4x/week for 30 min.)**
□**Regular Vigorous Exercise (i.e. work or recreation 4x/week for 30 minutes)**

Caffeine: □None □Coffee □Tea □Cola #of Cups/Cans Per Day?

Tobacco/Nicotine Use: □Never □Smoke □Chew □ _____# times/day □_____#years □ Quit

Alcohol: Do you drink alcohol?..... □Yes □No
If yes, what kind?_____How many drinks/day?_____/week?_____
Are you concerned about the amount you drink?..... □Yes □No

Other Drugs: Do you currently use recreational/street drugs?…… □Yes □No
If yes, what kind:_____

SCREENINGS/PREVENTION

	DATE	COMMENTS
Last Physical (Complete Physical Exam)		
Last Colonoscopy/Sigmoidoscopy		
Last Bone Density		
Last Vision Exam		
Last Dental Exam		
Last Mammogram		

MENTAL HEALTH

Is stress a major problem for you?……..	□Yes	□No
Do you feel depressed?……	□Yes	□No
Do you panic when stressed?……	□Yes	□No
Do you have problems with eating or your appetite?……	□Yes	□No
Do you cry frequently?……..	□Yes	□No
Have you ever attempted suicide?……..	□Yes	□No
Have you ever seriously thought about hurting yourself?……..	□Yes	□No
Do you have trouble sleeping?……	□Yes	□No
Have you ever been to a counselor?……	□Yes	□No

FOR WOMEN ONLY	
	DATE/COMMENTS
Sexual Preference: Male or Female	
Last Menstrual Period (LMP)?	
Menstrual Cycle Regular or Irregular?	
History of Abnormal Paps?	
Last Pap?	
History of Sexually Transmitted Diseases?	
# of Pregnancies,Births, Miscarriages?	
Have you had a D&C or Cesarean Section?	
# of Children and Genders	
Are you pregnant or breastfeeding?	
Method of Birth Control?	
Age of Menopause	
Age of Hysterectomy	
History of Ovarian Cancer or Uterine Problems?	
Any problems with control of urination?	
Do you get up at night to urinate?	
Any bladder, kidney or urinary tract infections in the last year?	
Do you have any abnormal vaginal discharge or irritation?	
Any hot flashes or sweating at night?	
Do you have menstrual tension, bloating, irritability or any other symptoms around your period?	
Have you experienced breast tenderness, lumps or nipple discharge?	

FOR MEN ONLY	
	DATE/COMMENTS
Sexual Preference: Male or Female	
Date of last prostate or rectal exam?	
Last PSA?	
History of Prostate Problems?	
History of Sexually Transmitted Diseases?	
Method of Birth Control?	
# of Children and Genders	
Any problems with control of urination?	
Do you get up at night to urinate?	
Do you feel pain or burning upon urination?	
Has the force of your urination decreased?	
Do you have burning or discharge from your penis?	
Any bladder, kidney or urinary tract infections in the last year?	
Any testicle pain or swelling or lumps?	
Any difficulty with erection or ejaculation?	