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.):*	☐ M ☐ F	**DOB:**
Marital Status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Date of last physical exam:	**PHARMACY:**	

PERSONAL HEALTH HISTORY

Allergies to Medications	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
Penicillin			NSAIDS			Steroids		
Sulfa			Cephalosporin			Opiods		
Iodine			Erythromycin			Other:		
Aspirin			Vaccine					

Reason For Visit			**Other**:
New Problem ☐	General Check UP ☐	Physical ☐	
Regular Visit ☐	Medication Refills ☐		
Test Review ☐	Recent Hospital Stay ☐		

Childhood illness:	**☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio**
Immunizations	**☐ Tetanus ☐ Hepatitis ☐ Influenza ☐ Pneumonia ☐ Chickenpox ☐ MMR** ***Measles, Mumps, Rubella***

Medical History	**YES**	**NO**	**Family**		**YES**	**NO**	**Family**
Neurological Problems				Seasonal Allergies			
Anxiety				Sinus issues			
Depression				Gout			
Mental Illness				Dental Problems			
Seizures				Thyroid			
Headaches				Arthritis			
Heart Disease :_____				Rheumatoid Arthritis			
Paralysis/ CVA				Digestive Problems			
Stroke Yr_____				Kidney Problems/ Stones / Disease			
Deep Vein thrombosis				Cholesterol			
Phlebitis				Hepatitis			
Cataracts				Lupus			
Glaucoma				Cancer: _____			
Diabetes				**OTHER:**			

Surgical Procedures	**YES**	**NO**	**Year**		**YES**	**NO**	**Year**		**YES**	**NO**	**Year**	
Eye Surgery				Hernia				Plastic Surgery				
Dental				Heart Procedure				Cancer				
Tonsils				Gallbladder				Urology				
Appendix				Skin				Gyn				
Lung Procedures				Bronchoscope			**OTHER**					
Gastro Intestinal				Endoscopy								
Gastro Intestinal				Colonoscopy								
Plastic Surgery												

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

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)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol? ☐ Mild ☐ Moderate ☐ Heavy How many Drinks per Week?				☐ Yes	☐ No
Tobacco	Do you use tobacco? ☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day				☐ Yes	☐ No
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Personal	Do you live alone?				☐ Yes	☐ No
	With Whom Do you Live?				☐ Yes	☐ No
Safety	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Are you sexually active?				☐ Yes	☐ No
	How many Sexual Partners have you had in the Last Year				☐ Yes	☐ No
	When was your Last HIV Screening	Date:_____			☐ Yes	☐ No
Health Maintenance History	Physical Exam	Date:_____			☐ Yes	☐ No
	Complete Blood work (CBC CMP LIPID U/A)	Date:_____			☐ Yes	☐ No
	When was your Last Electrocardiogram (EKG)	Date:_____			☐ Yes	☐ No
	Have you had an Echo	Date:_____			☐ Yes	☐ No
	Have you had a Carotid Ultra Sound	Date:_____			☐ Yes	☐ No
	Have you had a Cardiac Cauterization	Date:_____			☐ Yes	☐ No
	Have you Undergone a Cardiac Stress Test	Date:_____			☐ Yes	☐ No
	When was your Last Chest X-ray	Date:_____			☐ Yes	☐ No
	When was your last Dexa Scan (Osteoporosis Scan)	Date:_____			☐ Yes	☐ No
	Have you had a(n) Colonoscopy preformed	Date:_____			☐ Yes	☐ No
	Have you had a (n) Abdominal Ultra Sound preformed	Date:_____			☐ Yes	☐ No
	Have you had a (n) Pelvic Ultra Sound	Date:_____			☐ Yes	☐ No
	Have you had a (n) Bladder Ultra Sound	Date:_____			☐ Yes	☐ No
	Have you had a (n) Prostate Ultra Sound	Date:_____			☐ Yes	☐ No
	Have you had a Renal Ultra Sound in the past 6months	Date:_____			☐ Yes	☐ No
	Have you had a(n) EGD preformed	Date:_____			☐ Yes	☐ No
	Have you had a(n) Occult Blood Test Preformed	Date:_____			☐ Yes	☐ No
	Have you had any Lower Extremity Ultra Sounds	Date:_____			☐ Yes	☐ No
	Have you had a Diabetic Screening Exam	Date:_____			☐ Yes	☐ No
	Have you preformed a(n) Allergy Test	Date:_____			☐ Yes	☐ No
	Have you had a Sleep Study	Date:_____			☐ Yes	☐ No
	Have you had a Pulmonary test performed	Date:_____			☐ Yes	☐ No
	Have you had a Mammogram	Date:_____			☐ Yes	☐ No
	Have you had a Pap Smear	Date:_____			☐ Yes	☐ No
	Other:					

REVIEW OF SYSTEMS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL

		YES	NO			YES	NO
GENERAL SYMPTOMS	Fever			**Cardiovascular**	Palpitations		
	Night Sweats				Irregular beats		
	Fatigue				Fainting		
	Weight Change				Heart murmur		
Ear/Nose Mouth/Throat	Sinus Problems				Pain in Legs		
	Runny Nose				Blood Clots		
	Sore throat				Chest Pain		
	Vertigo				Poor Circulation		
	Hearing Loss				Pacemaker		
Gastrointestinal	Swallowing Pain			**Reparatory**	Chronic Frequent Coughs		
	Heart Burn				Wheezing		
	Hemorrhoids				Short of breathe		
Skin	Bruising				Sleep Apnea		
	Rash				Asthma		
	Sores				Emphysema		
	Lumps				TB Exposure		
	Moles			**Genitourinary**	Frequent Urination		
	Change in Mole				Blood in Urine		
Hematologic	Anemia				Incontinence		
	Blood transfusion				Kidney Stones		
	HIV				Kidney Disease		
	Liver Disease				Nocturnal urination		
Endocrine	Bone Disorder				Pelvic Pains		
	Osteoporosis				Vaginal Infections		
	Thyroid Disease			**Neurological**	Headaches		
MENTAL ILLNESS	Depression				Seizures		
	Anxiety				Syncope		
Musculoskeletal	Joint Pain				Fainting		
	Stiffness				Dizzy Spells		
	Weakness						
	Back Pain						

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

WOMEN ONLY

Age at onset of menstruation:	Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Date of last menstruation:	Number of pregnancies _____ Number of live births _____		
Period every _____ days	Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?		☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year? Any blood in your urine?		☐ Yes	☐ No
Any problems with control of urination?		☐ Yes	☐ No
Any hot flashes or sweating at night?		☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?		☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?		☐ Yes	☐ No

MEN ONLY		
Do you usually get up to urinate during the night? If yes, # of times _____	☐ Yes	☐ No
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Are you feeling Depressed Fatigued or Out of Energy	☐ Yes	☐ No
Do you have any Lumps or swelling of the testis	☐ Yes	☐ No

By signing this form, I indicate that all Health information provided for my Health Services is Accurate to my knowledge. I understand I must notify the Medical Staff of any changes in the information I have submitted.

*Patient Signature:*_____*Date:*_____