Associates in Family Medicine - M. Michelle Hamidi, MD

Confidential Health History Questionnaire - Past Medical Hisotry

Name: _____ Date of Birth: _____ Age: _____ Date: _____

ALLERGIES

(list any allergies to medicines or other substances) ☐ None

SURGERY/HOSPITALIZATION

Date	Reason	☐ None

MEDICAL PROBLEMS

List any chronic or recurrent medical problems - Date of onset

☐ None

List All Medication You Take Regularly (Prescription and Non-Prescription)

Medicine Dose ☐ None

CHECK ANY THAT YOU HAVE HAD OR NOW HAVE:

Past/Current		Past/Current	
☐	☐ Abnormal Electrocardiogram	☐	☐ Heart Attack
☐	☐ Abnormal Pap Smear	☐	☐ Heart Murmur or Heart Disease
☐	☐ AIDS or HIV	☐	☐ Hepatitis or Cirrhosis
☐	☐ AlcoholDrug Overuse/Abuse	☐	☐ Herniated or Ruptured Disc
☐	☐ Allergies or Hay Fever	☐	☐ Herpes
☐	☐ Anemia (low iron)	☐	☐ High Blood Pressure
☐	☐ Ankles swell frequently	☐	☐ Hodgkin's Disease, Lymphoma, or Leukemia
☐	☐ Anexiety or Panic Attacks	☐	☐ Intolerance of dairy/fatty Foods
☐	☐ Arthritis or Gout	☐	☐ Irregular Heartbeat
☐	☐ Asthma		
☐	☐ Frequent Backaches	☐	☐ Irritable Bowel Syndrome
☐	☐ Bladder Infection	☐	☐ Kidney Disease or Nephritis
☐	☐ Blood Clots or Bleeding Prob.	☐	☐ Kidney Stones
☐	☐ Blood in Bowel Movement	☐	☐ Lung Problems
☐	☐ Blood Transfusion	☐	☐ Lupus
☐	☐ Boils or Cysts - Recurrent	☐	☐ Malaria
☐	☐ Bone or Joint Disease	☐	☐ Seizures, Convulsions or Epilepsy
☐	☐ Bowel or Colon Disease	☐	☐ Meningitis
☐	☐ Breast Lumps	☐	☐ Migraine Headache
☐	☐ Bronchitis - Recurrent	☐	☐ Mole Changes
☐	☐ Bruise Easily	☐	☐ Muscle Disease or Weakness
☐	☐ Bursitis or Tendonitis	☐	☐ Pancreatitis
☐	☐ Cancer	☐	☐ Phlebitis
☐	☐ Chest Pain	☐	☐ Pleurisy
☐	☐ Chills or night sweats	☐	☐ Pneumonia
☐	☐ Cholesterol-Elevated	☐	☐ Polio
☐	☐ Chronic Cough	☐	☐ Problems with urination
☐	☐ Colitis	☐	☐ Rheumatoid Arthritis
☐	☐ Color-blindness	☐	☐ Rheumatic Fever
☐	☐ Concerns about fertility	☐	☐ Seizures, Convulsions or Epilepsy
☐	☐ Concussion or Head Injury	☐	☐ Sensory Changes
☐	☐ Constipation	☐	☐ Sexual Problems/Concerns
☐	☐ Depression or Suicide	☐	☐ Shortness or Breath
☐	☐ Diabetes	☐	☐ Sickle Cell Disease or Trait
☐	☐ Difficulty swallowing	☐	☐ Skin Disease - Chronic
☐	☐ Dizziness or Fainting	☐	☐ Skin Infections - Recurrent
☐	☐ Emphysema	☐	☐ Sleep Difficulties/Disorders
☐	☐ Excessive Stress	☐	☐ Sprains or Dislocations
☐	☐ Frequent colds/sinus problems	☐	☐ Stomach Pain
☐	☐ Frequent earaches	☐	☐ Stroke or Brain Attack
☐	☐ Frequent or painful urination	☐	☐ Swelling of joints
☐	☐ Frequent/severe sore throat	☐	☐ Thyroid Disease
☐	☐ Frequent/severe nosebleeds	☐	☐ Tremors/shaking of hands
		☐	☐ Tuberculosis (TB) or positive test
☐	☐ Gallbladder Disease or Gallstone	☐	☐ Ulcer Disease or Gastritis
		☐	☐ Unexpected weight loss
☐	☐ Glaucoma	☐	☐ Urinate frequently at night
		☐	☐ Varicose Veins
☐	☐ Gonorrhea, Syphilis or Chlamydia	☐	☐ Venereal Disease
		☐	☐ Wheezy or whistling chest
☐	☐ Growth on skin	☐	☐ Yellow Jaundice
☐	☐ Gum bleed easily		
☐	☐ Frequent/severe sore throat		
☐	☐ Hearing Problems		

IMMUNIZATION HISTORY

			DATE OF LAST
Chickenpox or Shot	☐ Yes	☐ No	
Hepatitis B Series or Shots	☐ Yes	☐ No	
Influenza Shot	☐ Yes	☐ No	
Pneumonia Shot	☐ Yes	☐ No	
Rubella Shot or Blood Test	☐ Yes	☐ No	
Tetanus Shot	☐ Yes	☐ No	

FAMILY HISTORY

	If Alive, Age	If Dead, Age and Cause
Father		
Mother		
Brother/Sister		
Spouse/Sig Other		
Son(s)/Daughter(s)		

Primary Language in Home:

PLEASE CHECK FOR ANY CONDITION WHICH APPLIES TO A BLOOD RELATIVE

Condition	Who
Alcohol/Drug Abuse	
☐ Allergies/Asthma	
☐ Arthritis/Gout	
☐ Bleeding Disorder	
☐ Cancer (Type)	
☐ Diabetes	
☐ Epilepsy/Seizures	
☐ Glaucoma	
☐ Heart Disease	
☐ High Blood Pressure	
☐ High Cholesterol	
☐ HIV/AIDS	
☐ Kidney Disease	
☐ Mental Illness	
☐ Migraine Headaches	
☐ Sickle Cell Condition	
☐ Stroke	
☐ Suicide/Depression	
☐ Thyriod Disease	
☐ Other	

SOCIAL HISTORY

My current status is:

With whom do you now live?

Highest education achieved?

Your Occupaton?

Exposure to hazardous condition/substances at work? ☐ No ☐ Yes

Type:

Religious preference/beliefs:

Do you have a living will? ☐ No ☐ Yes

Are you an organ donor? ☐ No ☐ Yes

PERSONAL HISTORY

QUESTIONS FOR WOMEN ONLY:

MENSTRUATION:

Age periods began: How often:

Date of last menstrual period:

Now Pregnant?	☐ Yes	☐ No
Vaginal Discharge?	☐ Yes	☐ No
PMS?	☐ Yes	☐ No
Menopause?	☐ Yes	☐ No
Unexplained Vaginal Bleeding?	☐ Yes	☐ No
Discharge from nipples?	☐ Yes	☐ No
Skin changes in breasts?	☐ Yes	☐ No

PREGNANCIES:

Total Number: Full Term:

Date of last Pap Smear:

Date of last mammogram:

Premature:

Miscarriages:

Abortions:

Tubal Pregnancies:

QUESTIONS FOR MEN ONLY:

Prostate Trouble?	☐ Yes	☐ No
Discharge from penis?	☐ Yes	☐ No
Sore on penis?	☐ Yes	☐ No
Do you examine your testicles?	☐ Yes	☐ No

QUESTIONS FOR MEN AND WOMEN ONLY:

What kind of Birth Control/Protection do you and/or your partner use?

How would you describe your sexual orientation?

Do you use sunscreen?	☐ Yes	☐ No
Do you always wear seatbelts?	☐ Yes	☐ No
Do you wear protective sports equipment?	☐ Yes	☐ No
Is your house a smoke-free house?	☐ Yes	☐ No
Do you have a working smoke detector?	☐ Yes	☐ No
Are there any guns/weapons in your home?	☐ Yes	☐ No
Do you floss your teeth regularly?	☐ Yes	☐ No
Do you wear dentures?	☐ Yes	☐ No

Last dental visit? Date:

Do you wear glasses/contacts? ☐ Yes ☐ No

Last eye exam? Date:

DIET, EXERCISE & HABITS:

Do you follow a special diet? If so, explain:

Current Weight? Desired? One year ago?

What kind of exercise do you do and how often?

TOBACCO USE:

Do you smoke? What type:?

If yes, how much per day: Per week?

Have you quit smoking? When?

Do you use other tobacco products? Type:

If so, how much?

ALCOHOL USE:

Do you drink alcohol? How many drinks per week?

Has anyone ever expressed concerns about your alcohol use?

If yes, please explain: