Placer Medical Center, Inc **Health History Questionnaire**
Phoenix Health and wellness, PC

Patient Name: _____ DOB: _____

Great healthcare is the result of great communication. At this practice, we want to understand everything we can about your ideas on healthcare, your concerns, and your goals. Keeping you well means knowing you well. Thank you for beginning our conversation before your visit by completing this information.

Main reason for today's visit: _____

Other Concerns: _____
_____
_____

ALLERGIES

Please list all allergies (medications, food, bee stings, etc.) and reactions to each.

ALLERGY	REACTION
1._____	_____
2._____	_____
3._____	_____
4._____	_____

MEDICATIONS

Please list all the medications you are currently taking. Include prescribed drugs and over-the-counter drugs, as well as vitamins and supplements.

NAME	STRENGTH	FREQUENCY TAKEN

IMMUNIZATION HISTORY (Please include immunizations and most recent date of administration)

Chickenpox	Date:_____	MMR (Measles, Mumps, Rubella)	Date:_____
Flu Shot	Date:_____	Pneumonia	Date:_____
Gardasil/HPV	Date:_____	Tdap (Tetanus and pertussis)	Date:_____
Hepatitis A	Date:_____	Tetanus	Date:_____
Hepatitis B	Date:_____	Zostavax (Shingles)	Date:_____
Meningococcus	Date:_____		

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PAST MEDICAL HISTORY: (Please check all that apply)

❑Anxiety Disorder	❑Diabetes - Insulin	❑Hiatal Hernia or Reflux	❑Osteoporosis
❑Arthritis	❑Diabetes - Non-Insulin	❑Disease	❑Polio
❑Asthma	❑Dialysis	❑HIV or AIDS	❑Pulmonary Embolism
❑Bleeding Disorder	❑Diverticulitis	❑High Cholesterol	❑Reflux or Ulcers
❑Blood Clots (or DVT)	❑Fibromyalgia	❑High Blood Pressure	❑Stroke
❑Cancer	❑Gout	❑Overactive Thyroid	❑Tuberculosis
❑Coronary Artery	❑Pacemaker	❑Kidney Disease	❑Other
❑Disease	❑Heart Attack	❑Leg/Foot Ulcers	_____
❑Claustrophobic	❑Heart Murmur	❑Liver Disease	

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Date of last Pap Smear ❑Normal ❑Anormal _____

Date of last Mammogram ❑Normal ❑Anormal _____

Age of first Menstrual cycle:_____ Date of last Menstrual Period:_____ Age at Menopause:_____

Number of pregnancies: _____ Number of Abortions: _____
Number of Births: _____ Number of Miscarriages: _____
Number of Cesarean Sections: _____

FAMILY HISTORY:

Grandmother (maternal)	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension
Grandfather (maternal)	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension
Grandmother (paternal)	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension
Grandfather (paternal)	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension
Father	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension

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Mother	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension
Brother	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension
Sister	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension
Other	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension

SOCIAL HISTORY:

Education	☐ Less than 8th grade ☐ High school graduate ☐ 2 year college ☐ 4 year college ☐ Post graduate	**Marital Status**	☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner
Exercise Level	☐ None ☐ Occasional ☐ Moderate ☐ Heavy	**Caffeine**	☐ None ☐ Occasional ☐ Moderate ☐ Heavy Cups/cans daily? _____
Drugs	Do you use illicit drugs?		If yes please list: ☐ Yes ☐ No
Alcohol	Do you drink alcohol?	☐ Yes ☐ No	If so how often? ☐ Occasionally ☐ Less than 3 times a week ☐ More than 3 times a week
Tobacco	Do you use tobacco?	☐ Yes ☐ No	If not currently, did you ever use? ☐ Cigarettes- _____ pks per day ☐ Chew- _____ pks per day ☐ Cigars-_____ each per day Number of years used: _____ Year quit: _____

PAST SURGICAL HISTORY:

SURGERY	REASON	YEAR	HOSPITAL

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REVIEW OF SYSTEMS:

Constitutional:	**Eyes:**	**Ears and Nose:**	**Mouth and Throat:**
☐ Fever ☐ Night sweats ☐ Weight gain ☐ Weight loss ☐ Exercise intolerance	☐ Dry eyes ☐ Vision change ☐ Irritation	☐ Difficulty hearing ☐ Ear pain ☐ Frequent nosebleeds ☐ Nose problems ☐ Sinus problems	☐ Sore throat ☐ Bleeding gums ☐ Snoring ☐ Dry mouth ☐ Mouth ulcer ☐ Oral abnormalities ☐ Teeth problems
Cardiovascular:	**Respiratory:**	**Gastrointestinal:**	**Genitourinary:**
☐ Chest pain ☐ Arm pain on exertion ☐ Shortness of breath when walking ☐ Shortness of breath when lying down ☐ Palpitations ☐ Known heart murmur	☐ Cough ☐ Wheezing ☐ Shortness of breath ☐ Coughing up blood ☐ Sleep apnea	☐ Abdominal pain ☐ Vomiting ☐ Change in appetite ☐ Diarrhea ☐ Vomiting blood ☐ Indigestion ☐ GERD	☐ Incontinence ☐ Difficulty urinating ☐ Blood in urine ☐ Increased frequency
Musculoskeletal:	**Integumentary:**	**Neurologic:**	**Psychiatric:**
☐ Muscle aches ☐ Muscle weakness ☐ Joint pain ☐ Back pain ☐ Swelling in extremities	☐ Abnormal mole ☐ Jaundice ☐ Rash ☐ Laceration	☐ Loss of consciousness ☐ Weakness ☐ Numbness ☐ Seizures ☐ Dizziness ☐ Migraines ☐ Headaches ☐ Tremors	☐ Depression ☐ Sleep disturbances ☐ Unsafe relationship ☐ Alcohol abuse ☐ Anxiety ☐ Hallucinations ☐ Suicidal thoughts
Endocrine:	**Hematologic/Lymphatic:**	**Allergic/Immunologic:**	**Other/not listed:**
☐ Fatigue	☐ Swollen glands ☐ Bruising ☐ Excessive bleeding	☐ Runny nose ☐ Sinus pressure ☐ Itching ☐ Hives ☐ Frequent Sneezing	

Please add any additional health information here:

Patient/Parent/Guardian/caregiver signature DATE

Physician Signature DATE