Tri-Valley
MEDICAL CENTER, INC.

HEALTH HISTORY QUESTIONNAIRE

Welcome to our office. All the following questions contained in this questionnaire are strictly confidential and will become part of your medical record. Please answer to the best of your knowledge. These questions will assist us in your comprehensive and efficient medical care. All questions contained in this questionnaire are optional and will be kept strictly confidential.

Name *(Last, First, M.I.)*: ☐M ☐F	**Date of Birth:**
Marital status: ☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed	
Race/Ethnicity: ☐Declined to specify ☐Caucasian ☐Asian ☐Middle Eastern ☐Hispanic ☐African-American ☐Other:	
Previous or referring physician: *please include name, address, & phone number*	**Date of last physical exam**:

PERSONAL MEDICAL HISTORY

IMMUNIZATIONS *(please include date given)*		
☐Tetanus (Tdap/Td)	☐Influenza	☐Hepatitis B
☐MMR	☐Pneumonia	☐Shingles
☐Varicella	☐Hepatitis A	☐Other:

CURRENT MEDICAL CONDITIONS *(circle all that apply)*		
AID/HIV	Coronary Artery Disease	Osteoporosis
Anemia	Depression	Prostate Problems
Anxiety	Diabetes	Renal Disease
Arthritis	Drug Dependency	Seasonal Allergies
Asthma	Fibromyalgia	Seizure Disorder
Atrial Fibrillation	Gout	Sleep Apnea
Bleeding Disorder	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*	
Name & Reaction	Name & Reaction

CURRENT MEDICATIONS: *Please list prescribed & over-the-counter drugs being taken*			
Name & Dosage	Frequency Taken	Name & Dosage	Frequency Taken

X _____

Patient Signature and today's date

Tri-Valley
MEDICAL CENTER, INC.

SURGERIES & OTHER HOSPITALIZATIONS			
Year	Reason	Hospital	Outcome

CHILDHOOD ILLNESSES: ☐Measles ☐Mumps ☐Rubella ☐Chickenpox/Varicella ☐Polio

DIAGNOSTIC STUDIES *(please include dates)*		
☐Colonoscopy	☐Upper Endoscopy	☐Mammogram
☐Bone Density Scan	☐Pap Smear	☐Other:

HEALTH HABITS AND PERSONAL SAFETY

Caffeine	☐None ☐Coffee ☐Tea ☐Cola	# Of cups/cans per day:
Alcohol	Do you drink alcohol?	☐ Yes ☐ No
	If yes, what kind? ☐Beer ☐Wine ☐Hard Liquor ☐Gin ☐Whiskey ☐Other:	
	How many drinks per week?	
Tobacco	Do you use tobacco?	☐ Yes ☐ No
	☐Cigarettes – pks./day: ☐Chew - #/day: ☐Pipe - #/day: ☐Cigars - #/day:	
	# of years used: Or year quit:	
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

	SIGNIFICANT HEALTH PROBLEMS	SIGNIFICANT HEALTH PROBLEMS
Father	☐Hyperlipidemia ☐Hypertension ☐Diabetes ☐Other:	**Children** ☐M/☐F
		☐M/☐F
Mother	☐Hyperlipidemia ☐Hypertension ☐Diabetes ☐Other:	☐M/☐F
		☐M/☐F
Sibling(s)	☐M/☐F	**Significant relative(s):**
	☐M/☐F	
Maternal **Grandmother**	☐Hyperlipidemia ☐Hypertension ☐Diabetes ☐Other:	
Grandfather	☐Hyperlipidemia ☐Hypertension ☐Diabetes ☐Other:	
Paternal **Grandmother**	☐Hyperlipidemia ☐Hypertension ☐Diabetes ☐Other:	
Grandfather	☐Hyperlipidemia ☐Hypertension ☐Diabetes ☐Other:	

X _____

Patient Signature and today's date