HEALTH QUESTIONNAIRE

NAME: ______ DATE: ______

BIRTHPLACE ______ BIRTHDATE ______ AGE ______ OCCUPATION ______

MAIN REASON FOR VISIT TODAY? ______

TODAY'S CURRENT COMPLAINTS/ CONCERNS? ______

MEDICATIONS/ VITAMINS SUPPLEMENTS

PLEASE LIST ALL DRUGS, VITAMINS AND DIETARY SUPPLEMENTS YOU ARE CURRENTLY TAKING. IF POSSIBLE, LIST STARTING DATE AND DOSAGE.

MEDICATIONS	DATE	DOSE	NUTRITIONAL SUPPLEMENTS	DOSE

	YES	NO	EFFECT
PENICILLINS	☐	☐	
SULFA	☐	☐	
IODINE	☐	☐	
SHELL FISH	☐	☐	

		EFFECT
OTHER:		
OTHER:		

LIST ALL HOSPITALIZATIONS, OPERATIONS (INCLUDING PLASTIC SURGERY) AND/OR SERIOUS INJURIES.

YEAR	HOSPITALIZATION-OPERATION-INJURY	HOSPITAL & LOCATION

CONFIDENTIAL - DO NOT PHOTOCOPY

NEW PATIENT MEDICAL HISTORY AND HEALTH QUESTIONNAIRE

NAME: ______________________ DATE: ______________

SEXUAL IDENTITY/ ORIENTATION:

[] STRICTLY HETEROSEXUAL
[] STRICTLY HOMOSEXUAL
[] UNKNOWN
[] TRANSGENDER
[] BISEXUAL
[] NOT SEXUALLY ACTIVE

PSYCHOLOGICAL HISTORY:

	PRESENTLY	IN THE PAST
PSYCHOTHERAPY	[]	[]
ANTIDEPRESSANTS	[]	[]

SPECIFY: ______________________

OTHER PSYCHIATRIC MEDICATIONS	[]	[]

SPECIFY: ______________________

HAVE YOU EVER BEEN ADMITTED TO A HOSPITAL FOR A PSYCHOLOGICAL EVALUATION? YES [ ] NO [ ]

IF YES, PLEASE SPECIFY WHEN AND THE DURATION OF STAY FOR EACH EPISODE: ______________________

____

____

SMOKING (CIGARETTES):

PAST USE:	PRESENT USE
________ PACKS/DAY	________ PACKS/DAY
________ YEARS TOTAL	________ YEARS TOTAL

ALCOHOL:

[] NONE
[] I SELDOM DRINK
[] I HAVE A DRINK ABOUT 3-5 TIMES PER WEEK
[] I DRINK DAILY

PLEASE STATE WHAT TYPE(S): ______________________

RECREATIONAL DRUG USE:

PLEASE DISCUSS WITH YOUR PROVIDER.

EXERCISE:

GYM?

CHECK ONE OF THE FOLLOWING STATEMENTS:

[] I MAKE NO EFFORT TO OBTAIN REGULAR EXERCISE
[] I LIVE AN ACTIVE LIFE AND GET MY WORKOUTS FROM DAILY LIVING ACTIVITIES SUCH AS WALKING, HIKING
[] I MAKE A MODEST EFFORT TO OBTAIN REGULAR EXERCISE (1-3X WEEKLY)
[] OBTAIN REGULAR EXERCISE 3 TO 5X PER WEEK (AT LEAST 30 MINUTES/SESSION)
[] OBTAIN REGULAR EXERCISE > 5X PER WEEK (AT LEAST 30 MINUTES/SESSION)

COMMENTS: ______________________

FAVORITE EXERCISE ACTIVITIES	DURATION	TIMES/WEEK

NAME: ______________________ DATE: ______________________

ILLNESSES & MEDICAL PROBLEMS (WITHIN PAST YEAR OR PRESENTLY):

	YES	NO
DIZZY SPELLS/VERTIGO	[]	[]
GLAUCOMA	[]	[]
EYE PROBLEMS	[]	[]
EAR TROUBLE	[]	[]
SINUS TROUBLE	[]	[]
DEAFNESS OR DECREASED HEARING	[]	[]
REPEATED NOSE BLEEDS	[]	[]
CHRONIC NASAL OBSTRUCTION	[]	[]
SWELLING IN NECK	[]	[]
ASTHMA	[]	[]
BRONCHITIS	[]	[]
EMPHYSEMA	[]	[]
PNEUMONIA	[]	[]
TUBERCULOSIS	[]	[]
OTHER LUNG PROBLEMS	[]	[]
SEASONAL ALLERGIES	[]	[]
HIGH BLOOD PRESSURE	[]	[]

	YES	NO
LOW BLOOD PRESSURE	[]	[]
BLEED EASILY	[]	[]
BRUISE EASILY	[]	[]
BLEEDING DISORDER	[]	[]
ANEMIA	[]	[]
HEART ATTACK	[]	[]
HEART MURMUR	[]	[]
ANKLE SWELLING	[]	[]
OTHER HEART CONDITION	[]	[]
STOMACH/DUODENAL ULCERS	[]	[]
COLITIS	[]	[]
DIVERTICULOSIS	[]	[]
OTHER BOWEL PROBLEMS	[]	[]
HEPATITIS	[]	[]
MONONUCLEOSIS	[]	[]
GALL BLADDER TROUBLE	[]	[]
STROKE	[]	[]
CONVULSION/SEIZURES	[]	[]
SCARLET FEVER	[]	[]

	YES	NO
ARTHRITIS	[]	[]
DIABETES	[]	[]
TROUBLE W/ ANESTHESIA	[]	[]
PARALYSIS	[]	[]
CANCER	[]	[]

YEAR AND TYPE OF CANCER ______________________

____

____

WOMEN ONLY

	YES	NO
TENDER BREASTS	[]	[]
DISCHARGE FROM NIPPLES	[]	[]
LUMPS OR RECENT CHANGE IN SIZE	[]	[]
FIBROCYSTIC DISEASE	[]	[]
MENSTRUAL PROBLEMS	[]	[]
LAST MAMMOGRAM	[]	[]
YEAR __________ NORMAL	[]	[]
LAST PAP SMEAR	[]	[]
YEAR __________ NORMAL?	[]	[]

DATE YOU BEGAN YOUR LAST MENSTRUAL PERIOD:

FAMILY HISTORY:

	YES	NO
TUBERCULOSIS	[]	[]
ASTHMA	[]	[]
GLAUCOMA	[]	[]
CANCER	[]	[]

	YES	NO
DIABETES	[]	[]
RHEUMATOID ARTHRITIS	[]	[]
HEART DISEASE	[]	[]
HIGH BLOOD PRESSURE	[]	[]

	YES	NO
LOW BLOOD PRESSURE	[]	[]
BLEEDING TENDENCY	[]	[]
BLOOD DISORDERS (SICKLE CELL ANEMIA, ETC.)	[]	[]
ULCER DISEASE	[]	[]

PHYSICAL AILMENTS:

	YES	NO
HEADACHES	[]	[]
NECK PAIN	[]	[]
SHOULDER PAIN	[]	[]
IRRITABILITY	[]	[]
INSOMNIA	[]	[]
NERVOUSNESS	[]	[]
BACK PAIN	[]	[]

	YES	NO
CHEST PAINS	[]	[]
SHORTNESS OF BREATH	[]	[]
WHEEZING	[]	[]
TIREDNESS	[]	[]
POOR APPETITE	[]	[]
WEIGHT LOSS	[]	[]
WEIGHT GAIN	[]	[]

	YES	NO
DIZZINESS	[]	[]
DIARRHEA	[]	[]
CONSTIPATION	[]	[]
BLOODY STOOLS	[]	[]
INDIGESTION	[]	[]
GAS (DYSPEPSIA)	[]	[]
HEARTBURN	[]	[]

____

____

____

MENTAL/ EMOTIONAL AILMENTS

	YES	NO
DEPRESSION	[]	[]
ANXIETY	[]	[]

	YES	NO
MOOD SWINGS	[]	[]
HELPLESS FEELINGS	[]	[]

	YES	NO
INDECISION	[]	[]
HEARTACHE	[]	[]

COMMENTS: ______________________

____

____

IS YOUR PARTNER, SPOUSE, OR ANYONE IN YOUR FAMILY ABUSING OR HARMING YOU? [] YES [] NO

NAME: ______________________ DATE: ______________________

STRESS:

OCCUPATION: ______________________ PRIOR OCCUPATIONS: ______________________

HOURS WORKED PER WEEK: ______________ VACATION TIME PER YEAR: ______________

JOB SATISFACTION RATING: [] GREAT [] OK [] FAIR [] POOR

FRIENDS:
[] I HAVE MANY WARM AND CLOSE RELATIONSHIPS
[] I HAVE MANY FRIENDS
[] I HAVE A FEW CLOSE FRIENDS
[] I DON'T HAVE ANY REAL CLOSE FRIENDS

HOW MANY TIMES HAVE YOU MOVED IN THE PAST TWO YEARS? ______________________

LIST STATES/ COUNTRIES WHERE YOU HAVE LIVED: ______________________

PLEASE EXPLAIN ANY RECENT STRESSFUL EVENTS: ______________________

STRESS REDUCTION ACTIVITIES (I.E., EXERCISE, MEDITATION, YOGA, RELIGION, ETC.): ______________________

THE FOLLOWING INFORMATION IS HELD IN THE STRICTEST CONFIDENCE.

DATE OF LAST HIV TEST: ______________ RESULT: ______________

CONFIDENTIAL - DO NOT PHOTOCOPY

PLEASE COMPLETE THE FOLLOWING PAGE ONLY IF YOU ARE HIV(+).

PLEASE COMPLETE THIS PAGE ONLY IF YOU ARE HIV(+).

NAME: ______________________ DATE: ______________________

CURRENT HISTORY

HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS?

	DATES		DATES
[ ] FEVERS	______	[ ] COUGHING	______
[ ] NIGHT SWEATS	______	[ ] SHORTNESS OF BREATH	______
[ ] FATIGUE	______	[ ] CHEST PAIN	______
[ ] UNINTENTIONAL WEIGHT LOSS	______	[ ] DIARRHEA	______
[ ] SWOLLEN LYMPH NODES	______	[ ] NAUSEA AND VOMITING	______
[ ] VISUAL CHANGES	______	[ ] URINARY TRACT PROBLEMS	______
[ ] HEADACHES	______	[ ] DECREASED LIBIDO/IMPOTENCE	______
[ ] RECURRENT SINUS PROBLEMS	______	[ ] VAGINAL INFECTIONS	______
[ ] ORAL (MOUTH) PROBLEMS	______	[ ] NUMBNESS/TINGLING OF ARMS OR LEGS	______
[ ] SWALLOWING PROBLEMS	______	[ ] LOSS OF BALANCE	______
[ ] SKIN RASHES /SORES	______	[ ] MEMORY LOSS OR CONFUSION	______

PAST MEDICAL HISTORY

[ ] ORAL CANDIDIASIS (THRUSH)	______	[ ] PNEUMOCYSTIS PNEUMONIA	______
[ ] HAIRY LEUKOPLAKIA	______	[ ] BACTERIAL PNEUMONIA	______
[ ] ORAL HERPES INFECTIONS	______	[ ] TUBERCULOSIS	______
[ ] GENITAL WARTS	______	[ ] KAPOSI'S SARCOMA	______
[ ] GONORRHEA	______	[ ] MAI/ MAC	______
[ ] INTESTINAL PROBLEMS	______	[ ] HIGH CHOLESTEROL	______
TYPE	______	[ ] CORONARY ARTERY DISEASE	______
[ ] HEPATITIS A	______	[ ] LAST TB SKIN TEST	______
[ ] HEPATITIS B	______	[ ] OTHER:	______
[ ] HEPATITIS C	______	[ ] OTHER:	______
[ ] CMV RETINITIS / COLITIS	______	[ ] EXPOSURE TO TUBERCULOSIS	
[ ] SYPHILIS		[ ] LYMPHOMA	
[ ] GENITAL OR RECTAL HERPES		[ ] CRYPTOCOCCAL MENINGITIS	______

HAVE YOU EVER BEEN DIAGNOSED WITH INTESTINAL PARASITES? [ ] YES [ ] NO

WHEN: ______________________ WHICH ONES: ______________________

HOW WERE THEY TREATED? ______________________

RECENT LABORATORY VALUES

DATE VIRAL LOAD (PCR OR BDNA) HELPER T-CELL NUMBER (CD4)______________

LIST ALL PRIOR MEDICATION REGIMENS AND DATES

______________________ ______________________ ______________________

______________________ ______________________ ______________________

SOCIAL HISTORY

DO YOU HAVE A SIGNIFICANT OTHER? [ ] YES HOW LONG: ______________ NO [ ]

DO YOU HAVE CLOSE CONTACT WITH YOUR FAMILY? [ ] YES [ ] NO

ARE YOU SEEING A THERAPIST OR IN A SUPPORT GROUP? [ ] YES [ ] NO

NAME: ______________________ PHONE: ______________________

WHERE HAVE YOU TRAVELED WITHIN THE PAST THREE YEARS (OUTSIDE THE USA)? WHEN? ______________________