



HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, M.I.): _____ M F DOB: _____

Date: _____ Marital status: Single Partnered Married Separated Divorced Widowed

Number of children: _____ How many live with you? _____ Occupation is/was: _____

Previous or referring doctor: _____ Date of last physical exam: _____

PERSONAL HEALTH HISTORY

Childhood Illness: Measles Mumps Rubella Chickenpox Rheumatic Fever Polio None

Immunizations and Dates: Tetanus _____ Pneumonia _____ Hepatitis A _____ Hepatitis B _____

Chickenpox _____ Influenza _____ MMR *Measles, Mumps, Rubella* _____ Meningococcal _____ None

Tests/Screenings and Dates: Eye Exam _____ Colonoscopy _____ Dexa Scan _____

Surgeries

Year _____ Reason _____ Hospital _____

Year _____ Reason _____ Hospital _____

Year _____ Reason _____ Hospital _____

Year _____ Reason _____ Hospital _____

I have had no surgeries

Other hospitalizations

Year _____ Reason _____ Hospital _____

Year _____ Reason _____ Hospital _____

Year _____ Reason _____ Hospital _____

Year _____ Reason _____ Hospital _____

I have never been hospitalized

Have you ever had a blood transfusion? Y N

Please list other physicians you have seen in the last 12 months, and for what reason.

Name (Last, First, M.I.): _____ DOB _____

YOUR MEDICAL HISTORY

Please indicate if **YOU** have a history of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Growth/Development Disorder | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anesthetic Complication | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rectal Cancer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Pain/Angina | <input type="checkbox"/> Reflux/GERD |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Seizures/Convulsions |
| <input type="checkbox"/> Autoimmune Problems | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Severe Allergy |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Bleeding Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke/CVA of the Brain |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> H IV | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Blood Transfusion(s) | <input type="checkbox"/> Hives | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bowel Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Liver Cancer | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Other Disease, Cancer, or Significant Medical Illness |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> NONE of the Above |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lung/Respiratory Disease | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Illness | |

List other past medical problems: _____

FAMILY MEDICAL HISTORY

Please indicate if **YOUR FAMILY** has a history of the following: (*ONLY include parents, grandparents, siblings, and children*)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> I am adopted and do not know biological family history | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Migraines | <input type="checkbox"/> Mother, Grandmother, or Sister developed heart disease before the age of 65 |
| <input type="checkbox"/> Family History Unknown | <input type="checkbox"/> Depression | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other Cancer | <input type="checkbox"/> Father, Grandfather, or Brother developed heart disease before the age of 55 |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rectal Cancer | |
| <input type="checkbox"/> Anesthetic Complication | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures/Convulsions | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Severe Allergy | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke/CVA of the Brain | |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Thyroid Problems | |
| <input type="checkbox"/> Bleeding Disease | <input type="checkbox"/> Lung/Respiratory Disease | <input type="checkbox"/> NONE of the Above | |
| <input type="checkbox"/> Breast Cancer | | | |

SOCIAL HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Exercise Do you exercise? Y N
If yes, how many minutes per week? _____

Diet Are you dieting? Y N If yes, are you on a physician prescribed medical diet?..... Y N
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?..... Y N
If yes, what kind? _____ How many drinks per week? _____

Are you concerned about the amount you drink? Y N
Have you considered stopping? Y N
Have you ever experienced blackouts?..... Y N
Are you prone to "binge" drinking? Y N
Do you drive after drinking? Y N

Tobacco Do you use tobacco?..... Y N
 Cigarettes – pks./day _____ or pks./week _____ Chew - #/day _____ Pipe - #/day _____ Cigars - #/day _____
 # of years _____ Previous tobacco user - year quit _____

Drugs Do you currently use recreational or street drugs?..... Y N
Have you ever given yourself street drugs with a needle? Y N
 I prefer to discuss with the physician

Sex Are you sexually active?..... Y N
If yes, are you and your partner trying for a pregnancy? Y N
If not trying for a pregnancy list contraceptive or barrier method used: _____

Mental Health Is stress a major problem for you? Y N
Do you feel depressed? Y N
Do you panic when stressed? Y N
Do you have problems with eating or your appetite?..... Y N
Do you cry frequently? Y N
Have you ever attempted suicide? Y N
Have you ever seriously thought about hurting yourself? Y N
Do you have trouble sleeping? Y N
Have you ever been to a counselor? Y N