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:

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

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)*

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

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

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

Patient's Signature:_____ Date:_____