HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name*(Last, First,M.I.):* ☐ M ☐ F	**DOB:**
Previous or referring doctor:	

PERSONAL HEALTH HISTORY

CIRCLE ANY MEDICAL PROBLEMS THAT ANOTHER DOCTOR HAS DIAGNOSED YOU WITH

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Whooping Cough					
High or Low Blood Pressure	Thyroid Disorder	Epilepsy	Allergies	Hernia	Blood\Plasma Transfusion
High Cholesterol	Arthritis	Migraines\Headaches	Hives or Eczema	Mono	Cancer
Heart Disease\Attack	Back Trouble	Asthma	Acid Reflux	Bladder Infection	Glaucoma
Mitral Valve Prolapse	Emotional, Mental Illness or Suicide Attempts	Pneumonia	Ulcers	Kidney Disease	STD \ Venereal Disease
Stroke	Anxiety\Depression	COPD	Hemorrhoids	Anemia	AIDS or HIV
Diabetes	ADD or ADHD	Tuberculosis	Hepatitis	Blood\Clot Disorder(DVT)	
Other Conditions:			Fractures \ Major Injuries:		

Other Treating Physicians \Specialists

Physician Name	Conditions Treated	Date of Last Visit

Previous Diagnostic Testing

Please give date and results. If you are unsure if you have had any of the following, please write "Unknown".

FEMALES: Date of Last Mammogram & Results?	
FEMALES: Date of last pap & Results?	Males: When was your last prostate exam?
Date of Last Chest X-Ray?	
Date of Last EKG?	Date of last Stress Test?
Date of Last Colonoscopy?	Date of last physical exam?

Patient Full Name:_____ DOB: _____

List ALL Prior Surgeries & Procedures –

You may use the back of the sheet if more room is needed

Year	Reason	Physician	Hospital\Facility

Other Hospitalizations

Year	Reason	Hospital

Immunization Status

Check all that apply and give DATES	Have all childhood immunizations been completed? ☐YES ☐NO	Did you bring immunization records? ☐YES ☐NO
	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐Chickenpox
	☐ TB Test Result	☐ Zostavax (Shingles)

Medications – Prescribed and Over The Counter

List your prescribed drugs and over-the-counter drugs, such as vitamins, inhalers, pain relievers.
If none, please write "ON NO MEDICATIONS" and initial.

Name the Drug	Strength	Frequency Taken

Allergies to medications\food

Name of the Drug\food	Reaction You Had	Last Exposure Date

Patient Full Name:_____ DOB: _____

HEALTH HABITS AND PERSONAL SAFETY

Who lives with you at your home?			How many children do you have?		
List names, gender and the years your children were born:					
What is your occupation?			What is your highest level of education completed?		
Do you have previous or current military experience?			If yes, which branch?		
About how many hours of sleep do you get each night?					
Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	Number of meals you eat in an average day?				
	Rank salt intake	☐ High	☐ Average	☐ Low	
	Rank fat intake	☐ High	☐ Average	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	Number of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?		How many drinks per week?		
	Have you ever felt the need to CUT down on alcohol use?			☐ Yes	☐ No
	Have you ever been angry when criticized about your alcohol use?			☐ Yes	☐ No
	Ever felt guilty about something that happened while you were drinking?			☐ Yes	☐ No
	Ever needed an "Eye Opener" in the morning?			☐ Yes	☐ No
Tobacco Use	Do you use tobacco?	# of years smoker:	Year quit:	☐ Yes	☐ No
	Cigarettes – pks./day:	Chew - #/day:	Pipe - #/day:	Cigars - #/day:	
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	If yes, are you sexually active with only one partner?			☐ Yes	☐ No
	Do you consider yourself at higher risk for STD's?			☐ Yes	☐ No
	Do you use contraception? If yes, List contraceptive or barrier method used:			☐ Yes	☐ No
Other Personal Safety	Do you have exposure at home or work to: Fumes, Dust, Solvents, Airborne Particles or Excessive Noise?			☐ Yes	☐ No
	Do you wear your seat belt?			☐ Yes	☐ No
	Do you wear a helmet when riding a bike?			☐ Yes	☐ No
	Do you have firearms in your home? (safety question only)			☐ Yes	☐ No
	If yes, is the firearm secured?			☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of an Advance Directive?			☐ Yes	☐ No
	Physical and/or mental abuses have become 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
	Do you have any tattoos?			☐ Yes	☐ No

Patient Full Name:_____ DOB: _____

FAMILY HEALTH HISTORY

	Sex	DATE OF BIRTH		Significant Health Problems\Cause of Death AND Age of Onset\Age at Death If no conditions exist, write "HEALTHY"
Mother			☐Alive ☐Deceased	
Father			☐Alive ☐Deceased	
Siblings	☐ M ☐ F		☐Alive ☐Deceased	
	☐ M ☐ F		☐Alive ☐Deceased	
	☐ M ☐ F		☐Alive ☐Deceased	
	☐ M ☐ F		☐Alive ☐Deceased	
	☐ M ☐ F		☐Alive ☐Deceased	
	☐ M ☐ F		☐Alive ☐Deceased	
Children	☐ M ☐ F		☐Alive ☐Deceased	
	☐ M ☐ F		☐Alive ☐Deceased	
	☐ M ☐ F		☐Alive ☐Deceased	
	☐ M ☐ F		☐Alive ☐Deceased	
Grandmother-*Maternal*			☐Alive ☐Deceased	
Grandfather-*Maternal*			☐Alive ☐Deceased	
Grandmother-*Paternal*			☐Alive ☐Deceased	
Grandfather-*Paternal*			☐Alive ☐Deceased	

Has anyone is your family including, Parents, Children, Grandparents, Aunts, Uncles or Siblings, had any of the following conditions? Please use the following key to indicate which relative

M=Mother F=Father GM=Grandmother GF=Grandfather B= Brother S=Sister A=Aunt U=Uncle

Heart Disease Before age 50	Stroke	Kidney Disease \ Kidney Stones \ Polycystic Kidneys	Hearing or Speech Problems
Heart Disease- any age	Epilepsy\Seizures	Glaucoma	Birth Defects
High Blood Pressure	Migraines\Headaches	Cataracts	Ovarian Cancer
High Cholesterol	Lung Disease\Tuberculosis	Alcohol or Drug Abuse	Breast Cancer
Diabetes	Allergies\Asthma	Emotional, Mental Illness or Suicide Attempts	Colon Cancer
Thyroid Disorder	Colitis \ Crohn's Disease	Learning Problems	AIDS or HIV
Anemia\Blood Disorders	Hepatitis \ Liver Disease	ADD	Family Violence
Other Conditions:		Other Cancers:	

AUTHORIZATION AND RELEASE:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of patient (or parent if minor) **Date**