

Health History Questionnaire

Name: (Last,First,M.I.):		DOB:
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Occupation:	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Previous or referring doctor:		Date of last physical exam:
How did you hear about our office: <input type="checkbox"/> Patient Referral <input type="checkbox"/> Insurance Company <input type="checkbox"/> Newspaper Ad <input type="checkbox"/> Yellow pages <input type="checkbox"/> Internet Search <input type="checkbox"/> Other:		

Personal Health History

Immunizations and Dates:			
<input type="checkbox"/> Tetanus	<input type="checkbox"/> TDAP	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> MMR
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Chickenpox	

Medical History:		
<input type="checkbox"/> Allergies	<input type="checkbox"/> Elevated Cholesterol	<input type="checkbox"/> Mumps
<input type="checkbox"/> Anemia	<input type="checkbox"/> Frequent infections	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> Peripheral Vascular Disease
<input type="checkbox"/> Asplenia	<input type="checkbox"/> GERD	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Asthma	<input type="checkbox"/> GI disorders	<input type="checkbox"/> Polio
<input type="checkbox"/> Bowel irregularity	<input type="checkbox"/> Gout	<input type="checkbox"/> Pregnancy currently
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Headache	<input type="checkbox"/> Prostate Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Renal dysfunction
<input type="checkbox"/> Chronic liver disease	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Chronic rashes	<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Clotting disorder	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> COPD	<input type="checkbox"/> HIV Infections	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Stroke/TIA
<input type="checkbox"/> Depression	<input type="checkbox"/> Illicit drug use	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Developmental Disability	<input type="checkbox"/> Immediately postpartum	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Iron deficiency	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Diet related illness (obesity)	<input type="checkbox"/> Lactose intolerance	<input type="checkbox"/> Other
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Measles	
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Menopausal or postmenopausal	

Surgeries:		
Year	Reason	Hospital

Other Hospitalizations:		
Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins:		
Name of drug	Strength	Frequency Taken

Allergies:	
Name of drug	Reaction you had

Family Health History: <input type="checkbox"/> Adopted/Unknown		
Relative	Age	Significant Health Problems
Father <input type="checkbox"/> Living <input type="checkbox"/> Deceased		
Mother <input type="checkbox"/> Living <input type="checkbox"/> Deceased		
Siblings	M <input type="checkbox"/>	
	F <input type="checkbox"/>	
	M <input type="checkbox"/>	
	F <input type="checkbox"/>	
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

Screening for Men & Women:		
Test	Date	Result
Colonoscopy		
Bone Density		
Rectal Exam		
Mammography		
Complete blood tests		

Test for blood in stool		
Pelvic and pap test (women only)		
Chest x-ray		
PSA		

Social History:			
Exercise	<input type="checkbox"/> No Exercise <input type="checkbox"/> Mild exercise (i.e. climb stairs, walk 3 blocks) <input type="checkbox"/> Occasional vigorous exercise (i.e. work or recreation, less than 4x/week for 30 min) <input type="checkbox"/> Regular vigorous exercise (i.e. work or recreation 4x/week for 30 min)		
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola # of cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per day?		
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Cigarettes – Pks./day	Chew-#/day	Pipe-#/day
	# of years		Or year quit
Drugs	Do you want to discuss any drug use with your provider?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex	Are you sexually active?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you live alone?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have a glasses?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal Safety	Do you have hearing aids?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have an advance directive and/or living will?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Would you like information on the preparation of these?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physical and/or mental abuse have also 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Women Only:	
Age at onset of menstruation:	Period every days
Date of last menstruation:	
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of pregnancies:	Number of live births:
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Men Only:	
Do you often get up to urinate during the night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes <input type="checkbox"/> No