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:				

Allergies /Sensitivities	**Reaction**

List your prescribed medications and over-the-counter medications ☐ See List

Name the Medication	Strength/Frequency	Why taken

PERSONAL HEALTH HISTORY

Have you <u>ever</u> had any of the following medical problems? Please <u>explain below.</u>

	Date Diagnosed		Date Diagnosed		Date Diagnosed
Allergy/Immunology: ☐ Seasonal Allergies		Respiratory: ☐ Asthma ☐ Emphysema/COPD		Psychiatry: ☐ Alcoholism ☐ Anxiety ☐ Chemical Dependence ☐ Depression	
Cancer: ☐ Cancer; Type:_____.		Musculoskeletal: ☐ Arthritis ☐ Gout ☐ Pain; Type:_____.		Endocrine: ☐ Diabetes, Type 1 ☐ Diabetes, Type 2 ☐ Thyroid Problems ☐ Weight Gain ☐ Weight Loss	
Infectious Disease: ☐ HIV/AIDS ☐ Tuberculosis/Positive TB Test		Gastroenterology: ☐ Bowel Problems ☐ GERD ☐ Hemorrhoids/Rectal Problems ☐ Hepatitis: ☐A ☐B ☐C (specify) ☐ Hernia; Type:_____. ☐ Liver Problems ☐ Stomach Ulcers ☐ Upper GI Problems		Hematology: ☐ Anemia ☐ Bleeding/Clotting Disorders	
HEENT: ☐ Cataracts ☐ Hearing Problems ☐ Sinus Issues (chronic) ☐ Other Eye Problems		Neurology: ☐ Epilepsy ☐ Headaches ☐ Memory Concerns ☐ Neuropathy		Congenital Abnormalities: ☐ Cerebral Palsy	
Cardiovascular: ☐ Atrial fibrillation ☐ Palpitations ☐ Heart Murmur ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol		Genitourinary: ☐ Kidney/Bladder Problems		Skin: ☐ Psoriasis/Eczema ☐ Acne ☐ Abnormal Lesions ☐Other:	

Surgeries/Hospitalizations (Do not include normal pregnancies and deliveries)

Year	Procedure/Reason	Hospital

PREVENTATIVE CARE

Date of Last Preventative Exam:

Immunization	**Date of vaccination**
Tdap (Tetanus/Diptheria/Pertussis)	
Zostavax (Shingles)	
Pneumovax (Pneumonia)	

Study	**Date**	**Normal/Abnormal**	**Facility/Location**
Colonoscopy		☐ **Normal** ☐ **Abnormal**	
DEXA Scan		☐ **Normal** ☐ **Abnormal**	
Mammogram		☐ **Normal** ☐ **Abnormal**	
PSA (Prostate Exam)		☐ **Normal** ☐ **Abnormal**	
ECG		☐ **Normal** ☐ **Abnormal**	
PAP Smear		☐ **Normal** ☐ **Abnormal**	

HEALTH HABITS AND PERSONAL SAFETY

Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	**Living with:**
Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drinks ☐ Other:	
	# of ounces per day?	
Alcohol	Do you drink alcohol? ☐ Yes ☐ No	
	If yes, what kind?	
	How often?	
Tobacco	Do you use tobacco products? ☐ Yes ☐ No Age or year you started: Age or year you quit:	
	☐ Cigarettes – pks./day: ☐ E cigs – #/day: ☐ Chew - #/day: ☐ Pipe - #/day: ☐ Cigars - #/day:	
	Exposure to second-hand smoke? ☐ Yes ☐ No	
Drugs	Do you currently use recreational or street drugs? (please specify) ☐ Yes ☐ No	
	Method of use (injection, inhalation, etc)? ☐ Yes ☐ No	
Gambling	Do you gamble? ☐ Yes ☐ No	
Exercise	☐ Sedentary/No exercise	
	☐ Yes Minutes/Day:_____ Days/Week:_____ Type of Exercise:_____.	
Occupation		

FAMILY HEALTH HISTORY

☐ ADOPTED

PLEASE SPECIFY IF INDIVIDUALS ARE LIVING OR DECEASED. ALSO INDICATE MATERNAL OR PATERNAL GRANDPARENTS.

Condition	Father	Mother	Sibling	Grand-parent	**Condition**	Father	Mother	Sibling	Grand-parent
Alcoholism					Epilepsy				
Allergies					Heart Problems				
Anxiety					High Blood Pressure				
Arthritis					High Cholesterol				
Asthma/Hay Fever					Kidney Disease				
Birth Defects					Leukemia				
Cancer (Breast)					Liver Problems				
Cancer (Prostate)					Migraines				
Cancer (other)					Obesity				
Colon/Bowel Problems					Stomach Ulcers				
Depression					Stroke				
Diabetes					Other:				
Emphysema/COPD					Other:				

Printed Name of patient/legal guardian:	Date:
Patient/legal guardian Signature:	