



HEALTH HISTORY QUESTIONNAIRE

Date: _____

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

Name (*Last, First, MI*): _____ Male Female DOB: _____

Marital Status: Single Partnered Married Separated Divorced Widowed _____

Previous of Referring Provider: _____ Date of Last Physical Exam: _____

PERSONAL HEALTH HISTORY

Childhood Illness: Measles Mumps Rubella Chickenpox Rheumatic Fever Polio _____

Immunizations & Dates:

Tetanus _____ Pneumovax _____

Hepatitis A _____ Hepatitis B _____

Chickenpox _____ MMR *Measles, Mumps, Rubella* _____

Influenza _____ Other _____

List any medical problems that other providers have diagnosed:

Surgeries:

Year	Reason	Hospital
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_____	_____	_____
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_____	_____	_____
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_____	_____	_____
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Other Hospitalizations:

Year	Reason	Hospital
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_____	_____	_____
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_____	_____	_____
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_____	_____	_____
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Have you ever had a Blood Transfusion? Yes No _____

If yes, Approximate date? _____ Do you know your Blood Type? _____

List your prescription drugs and over-the-counter drugs, such as vitamins, supplements and inhalers:

Name of Drug	Strength	Frequency Taken

List any Allergies to Medications:

Name of Drug	Reaction You Had

HEALTH & PERSONAL SAFETY

Exercise:

- Sedentary (*No Exercise*)
- Mild Exercise (*i.e., climb stairs, walk 3 blocks, golf*)
- Occasional vigorous exercise (*i.e., work or recreation, less than 4 times per week for 30 minutes*)
- Regular vigorous exercise (*i.e., work or recreation, 4 times a week for 30 minutes*)

Diet:

- Are you dieting? Yes No
- If yes, are you under a doctor's supervision? Yes No
- Are you a Vegetarian? Yes No

Caffeine:

- None Coffee Tea Cola
- Number of cups or cans per day?

Alcohol:

- Do you drink alcohol? Yes No
- How many drinks per week?
- Are you concerned about the amount you drink? Yes No
- Have you considered stopping? Yes No
- Have you ever experienced blackouts? Yes No
- Are you prone to "Binge" drinking? Yes No
- Do you drive after drinking? Yes No

Children: _____ Male Female
 _____ Male Female
 _____ Male Female
 _____ Male Female
 _____ Male Female
 _____ Male Female

Grandmother: _____
 Maternal
 Grandfather: _____
 Maternal
 Grandmother: _____
 Paternal
 Grandfather: _____

MENTAL HEALTH

Is stress a major problem for you? _____ Yes No
 Do you feel depressed? _____ Yes No
 Do you panic when stressed? _____ Yes No
 Do you have trouble sleeping? _____ Yes No
 Do you cry frequently? _____ Yes No
 Have you ever seriously thought about hurting yourself? _____ Yes No
 Have you ever attempted suicide? _____ Yes No
 Do you have any problems with eating or your appetite? _____ Yes No
 Have you ever been to a counselor? _____ Yes No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin _____	<input type="checkbox"/> Chest/Heart _____	<input type="checkbox"/> Recent changes in: _____
<input type="checkbox"/> Head/Neck _____	<input type="checkbox"/> Back _____	<input type="checkbox"/> Weight _____
<input type="checkbox"/> Ears _____	<input type="checkbox"/> Intestinal _____	<input type="checkbox"/> Energy level _____
<input type="checkbox"/> Nose _____	<input type="checkbox"/> Bladder _____	<input type="checkbox"/> Ability to sleep _____
<input type="checkbox"/> Throat _____	<input type="checkbox"/> Bowel _____	<input type="checkbox"/> Other pain/discomfort _____
<input type="checkbox"/> Lungs _____	<input type="checkbox"/> Circulation _____	_____

MEN ONLY

Do you usually get up to urinate during the night? Yes No
If yes, how many times _____

Do you feel pain or burning with urination? Yes No

Have you noticed any blood in your urine? Yes No

Do you feel a burning discharge from your penis? Yes No

Has the force of your urination decreased? Yes No

Have you had any kidney, bladder, or prostate infections within the past 12 months? Yes No

Do you have any problems emptying your bladder completely? Yes No

Any difficulty with erection or ejaculation? Yes No

Any testicle pain or swelling? Yes No

Date of last prostate and rectal exam? _____

WOMEN ONLY

Age at onset of menstruation: _____

Date of last menstruation: _____

Period every _____ days

Heavy periods, irregularity, spotting, pain, or discharge? Yes No

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? Yes No

Number of pregnancies: _____

Number of live births: _____

Are you pregnant or breast feeding? Yes No

Have you had a D&C, hysterectomy, or Cesarean? Yes No

Any urinary tract, bladder, or kidney infections within the past 12 months? Yes No

Have you noticed any blood in your urine? Yes No

Do you have any problems with control of urination? Yes No

Have you had any hot flashes or sweating at night? Yes No

Have you experienced any recent breast tenderness, lumps, or nipple discharge? Yes No

Date of last pap and rectal exam: _____