HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. All questions contained in the questionnaire are optional and will be kept strictly confidential.

Patient Name: _____________________________ ID #: _________________ DOB: ______/______/______

Main Reason for today's visit: ____
____

FAVORITE PHARMACY : ____
WHO IS YOUR PRIMARY CARE PROVIDER: ____

ALLERGIES

ALLERGY	REACTION
____	____
____	____
____	____

MEDICATIONS

DRUG NAME	**STRENGTH**	**FREQUENCY TAKEN**

IMMUNIZATION HISTORY:

Circle all that apply and report most recent date.

Chickenpox	Date: ___________	MMR (Measles, Mumps, Rubella)	Date: ____________
Flu Shot	Date: ___________	Pneumonia	Date: ____________
Gardasil/HPV	Date: ___________	Tdap (Tetanus and Pertussis)	Date: ____________
Hepatitis A	Date: ___________	Zostavax (Shingles)	Date: ____________
Hepatitis B	Date: ___________	Meningococcus	Date: ____________

FAMILY HEALTH HISTORY

Mark all that apply

Relation	Alcoholism	Arthritis	Depression	Cancer	Diabetes	Genetic Disease	Heart Disease	Hypertension	Osteoporosis	Stroke
Father										
Mother										
Brother/Sister										

HEALTH HISTORY QUESTIONNAIRE

Brother/Sister										
Grandfather (Paternal)										
Grandmother (Paternal)										
Grandfather (Maternal)										
Grandmother (Maternal)										

Other: ____

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR

Most recent colonoscopy: ____

PAST MEDICAL HISTORY

Please make all that apply:

Anxiety Disorder
Arthritis
Asthma
Bleeding Disorder
Blood Clots (DVT)
Cancer
Diabetes- Insulin
Diabetes-Non-Insulin
Dialysis
Diverticulitis
Gout
Has Pacemaker
Heart Attack
Heart Disease
Heart Murmur
Hepatitis: _____
Hiatal Hernia
HIV or AIDS
High Cholesterol
High Blood Pressure
Kidney Disease
Kidney Stones
Leg/Foot Ulcers
Liver Disease
Osteoporosis
Polio
Pulmonary Embolism
Reflux/GERD
Stroke
Tuberculosis
Thyroid Disease
Other:______________________
Other: ______________________

(WOMEN ONLY) OBSTRETIC AND GYNECOLOGICAL HISTORY

Date of last menstrual period: ___________________________ OR Age of Menopause: ______________________________

Number of pregnancies: ______ Births: ______ Miscarriages: ______ Abortions: ______

Cesarean sections: Y N If yes, then number: _________ Year of each Cesarean section? ____________________________

Date of most recent mammogram: ____________________________

SOCIAL HISTORY:

Have you ever used tobacco? Y or N If yes, how much? Cigarettes: ____

Chew: ____

Cigars: ____

HEALTH HISTORY QUESTIONNAIRE

Years in use: ____

Year Quit ____

Do you live alone or with other? _________________________

Advance Directives? Living Will Power of Attorney If yes, where are they filed: _____________________________________

Employed: Y or N Occupation: ____

Highest level of education? ____

General Stress level? Low Medium High

Number of children? _________________________________

Gun's Present in home? Y or N

Do you drink alcohol? Y or N If so, how many drinks per week? ____

Caffeine Intake: None Occasional Moderate Heavy # of cups per day? ____

Do you currently use recreational or street drugs? Y or N If yes, List: ____

Do you follow a special diet? Y or N If yes, what? ____

Exercise Level? (Circle One) None Occasional Moderate Heavy

Are you sexually active? Y or N If Yes: Current sexual partner is : Male Female

Do you use condoms? Y or N

Other birth control methods used: ____

Interested on being screened for STD's? Y or N

Smoke alarm/CO2 detector in home? Y or N

Are you exposed to second hand smoke? Y or N

Do you wear you seat belt routinely? Y or N

Do you use sunscreen routinely? Y or N

Alcohol- Years of use: _______

How many days in the past year have you had a heavy drinking consumption? (4+ Female, 5+ Male) ______________
(Heavy drinking for females is 4 or more in a day, and for males 5 or more in a day.)

How many days in the past year have you used recreational drugs or used a prescription medication for non-medical reasons?

Age 0-21 Questions:

Sporting Activities: ___________________________________

Parents Marital Status: Single - Married - Widowed - Divorced - Separate - Partner - Other ____________________

Home Situation (who does child live with): Both Parents - Mother – Father- Relatives - Adoptive Parents- Foster Parents- Other

Number of Siblings: _______ Childcare: Home – Relatives – Private Sitter – Daycare/Preschool

Are there pets in the home? Y or N What type of animals? ____

Insect repellent used routinely? Y or N Year in School: _______ School Name: ____________________________________

Pool Exposure? Y or N Bike Helmets? Y or N Fluoride status of home water? Fluoridated – Non-fluoridated – Unknown

Bully or Bullying problems? Y or N

Have there been changes in family/ social setting? Y or N ____

Any other important information? ____

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