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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 THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	**REACTION**
1._____	_____
2._____	_____
3._____	_____

FAVORITE PHARMACY: _____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____
7._____	_____	_____
8._____	_____	_____

IMMUNIZATION HISTORY

Immunizations and most recent date:

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

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear	Date _____	Abnormal	Bleeding between periods
Last Mammogram	Date _____	Abnormal	Heavy periods
Age of first menstrual period: _____			Extreme menstrual pain

Date of last menstrual period or age of menopause: _____

Number of pregnancies: _____ births: _____

miscarriages: _____ abortions: _____

Cesarean sections If yes, then number: _____

Vaginal itching, burning, or discharge

Wake in the night to go to the bathroom

Hot flashes

Breast lump or nipple discharge

Painful intercourse

Sexually active

Current sexual partner is Female Male

Do you use condoms Yes No

Other Birth control method used:_____

Interested in being screened for STDï¿½s

PAST MEDICAL HISTORY

Please check all that apply:

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

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1. _____	_____	_____	_____
1. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Grandfather (maternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Grandmother (paternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Grandfather (paternal)	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Father	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Mother	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Brother/Sister	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Brother/Sister	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke
Other:_____	Y/N	_____	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke

SOCIAL HISTORY

Education Less than 8th grade **Caffeine** None If not currently, did you ever use

High school
2 year college 4 year college
Post graduate

Marital Status Married Single
Divorced Separated Widowed
Domestic partner

Exercise Level
None (No exercise)
Occasional exercise
Moderate exercise
High level exercise

Occasional Moderate Heavy
# of cups/cans per day? ____

Alcohol Do you drink alcohol?
Yes No
If so, how often?
Occasionally < 3 times a week
> 3 times a week
How many drinks per week?
__

Tobacco Do you use tobacco?
Yes No

tobacco? Yes No
Cigarettes -____pks./day
Chew - ____/day
Cigars - _____/day
# of years____
Or year quit _____

Drugs Do you currently use recreational or street drugs? Yes No
If yes, list:
_____
_____

REVIEW OF SYSTEMS

Please check all that apply:	**Ears/Nose/Mouth/Throat**	**Genitourinary**	**Neurological**
Allergic/Immunologic	Bleeding Gums	Blood in Urine	Dizziness
Frequent Sneezing	Difficulty Hearing	Difficulty Urinating	Fainting
Hives	Dizziness	Incomplete Emptying	Headaches
Itching	Dry Mouth	Increased Urinary Frequency	Memory Loss
Runny Nose	Ear Pain	Urinary Loss of Control	Migraines
Sinus Pressure	Frequent Infections	**Hematologic/Lymphatic**	Numbness
Cardiovascular	Frequent Nosebleeds	Easy Bruising/Bleeding	Restless Legs
Arm Pain on Exertion	Hoarseness	Swollen Glands	Seizures
Chest Pain on Exertion	Mouth Breathing	**Integumentary (Skin)**	Weakness
Chest Heaviness/Pressure on Exertion	Mouth Ulcers	Changes in Moles	**Psychiatric**
Irregular Heart Beats (Palpitations)	Nose/Sinus Problems	Dry Skin	Alcohol Overuse
Known Heart Murmur	Ringing in Ears	Eczema	Anxiety/Stress
Light-headed on Standing	**Endocrine**	Growth/Lesions	Depression
Shortness of Breath When Lying Down	Fatigue	Itching	Do Not Feel Safe in Relationship
Shortness of Breath When Walking	Increased	Jaundice (Yellow Skin/Eyes)	Mania
Swelling (edema)	Thirst/Hunger/Urination	Rash	Sleep Problems
Constitutional	**Gastrointestinal**	**Musculoskeletal**	**Respiratory**
Exercise Intolerance	Abdominal Pain	Back Pain	Cough
Fatigue	Black or Tarry Stool	Joint Pain	Coughing Up Blood
Fever	Blood in Stool	Muscle Aches	Shortness of Breath
Weight Gain (____lbs)	Change in Appetite	Muscle Weakness	Sleep Apnea
Weight Loss (____lbs)	Frequent Indigestion		Snoring
Eyes	Hemorrhoids		Wheezing
Dry Eyes	Trouble Swallowing		
Irritation	Vomiting		
Vision Change	Vomiting Blood		
Date of Last Exam:_____			

Please add any other information about your health that you would like your provider to know here:
_____

_____ _____
Parent, Guardian, or Caregiver Signature Date