**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.**

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| ALLERGY1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | REACTION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**FAVORITE PHARMACY**

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|   **inhalers.**DRUG NAME1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_8.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | **MEDICATIONS****Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and**STRENGTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | FREQUENCY TAKEN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|   | **IMMUNIZATION HISTORY** |  |
| **Immunizations and most recent date:**☐ Chickenpox☐ Flu Shot☐ Gardasil/HPV☐ Hepatitis A☐ Hepatitis B | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |  ☐ Meningococcus☐ MMR *(Measles, Mumps, Rubella)*☐ Pneumonia☐ Tdap *(Tetanus and pertussis)*☐ Tetanus | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ☐ Zostavax *(Shingles)*  | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  **(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY**Last PAP Smear Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Abnormal ☐ Bleeding between periodsLast Mammogram Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Abnormal ☐ Heavy periodsAge of first menstrual period: \_\_\_\_\_\_\_\_ ☐ Extreme menstrual painDate of last menstrual period or age of menopause: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Vaginal itching, burning, or discharge Number of pregnancies: \_\_\_\_\_\_ births: \_\_\_\_\_\_\_ ☐ Wake in the night to go to the bathroom miscarriages: \_\_\_\_\_\_ abortions: \_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Hot flashes☐ Cesarean sections If yes, then number: \_\_\_\_\_\_ ☐ Breast lump or nipple discharge☐ Painful intercourse☐ Sexually active Current sexual partner is ☐ Female  Do you use condoms ☐ Yes ☐ No Other Birth control method used:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Interested in being screened for STDs  | ☐ Male |

**Please check all that apply:**

☐ Anxiety Disorder

☐ Arthritis ☐ Asthma

☐ Bleeding Disorder

☐ Blood Clots (or DVT)

☐ Cancer

☐ Coronary Artery Disease

☐ Claustrophobic

☐ Diabetes - Insulin

☐ Diabetes - Non-Insulin

☐ Dialysis

# PAST MEDICAL HISTORY

☐ Diverticulitis

☐ Fibromyalgia

☐ Gout

☐ Has Pacemaker

☐ Heart Attack

☐ Heart Murmur

☐ Hiatal Hernia or Reflux Disease

☐ HIV or AIDS

☐ High Cholesterol

☐ High Blood Pressure

☐ Overactive Thyroid

|  |  |
| --- | --- |
|  | **Tobacco** Do you use tobacco? ☐ Yes ☐ No |

☐ Kidney Disease

☐ Kidney Stones

☐ Leg/Foot Ulcers

☐ Liver Disease

☐ Osteoporosis

☐ Polio

☐ Pulmonary Embolism

☐ Reflux or Ulcers

☐ Stroke

☐ Tuberculosis

☐ Other

|  |  |  |
| --- | --- | --- |
|  | **PAST SURGICAL HISTORY** |  |
| **SURGERY**1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | **REASON**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **YEAR**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **HOSPITAL**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|   |  |  | **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

☐ 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

|  |  |  |  |
| --- | --- | --- | --- |
| **Caffeine**   **Alcohol** | ☐ None ☐ Occasional☐ Moderate ☐ Heavy # of cups/cans per day? \_\_\_\_Do you drink alcohol? ☐ Yes ☐ No If so, how often? |  **Drugs** | If not currently, did you ever use tobacco? ☐ Yes ☐ No ☐ Cigarettes -\_\_\_\_pks./day☐ Chew - \_\_\_\_/day☐ Cigars - \_\_\_\_\_/day☐ # of years\_\_\_\_Or year quit \_\_\_\_\_\_\_\_\_\_Do you currently use recreational or |

☐ Occasionally ☐ < 3 times a week street drugs? ☐ Yes ☐ No

☐ > 3 times a week If yes, list: How many drinks per week? \_\_

# REVIEW OF SYSTEMS

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

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

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient,Parent, Guardian, or Caregiver Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date |