Patient Name_____ DOB_____

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:**

FAVORITE PHARMACY (Name and Phone Number)

_____

_____

MEDICATIONS

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

Drug Name	**Dose**	**Frequency**

IMMUNIZATION HISTORY

Immunizations and most recent date:

Flu Shot Date:_____
Pneumonia Date:_____
Tdap (Tetanus and pertussis) Date:_____
Zostavax (Shingles) Date:_____

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ Normal or Abnormal (Circle One) Last Mammogram Date _____Normal or Abnormal (Circle One)

Age of first menstrual period: _____ Date of last menstrual period or age of menopause (Circle Which One): _____

Number of pregnancies: _____ births: _____miscarriages: _____ abortions: _____ living children: _____

Cesarean sections Yes or No (Circle One) If yes, then number: _____

- ○ Bleeding between periods
- ○ Heavy periods
- ○ Extreme menstrual pain
- ○ Vaginal itching, burning, or discharge
- ○ Wake in the night to go to the bathroom: If so, how many times_____
- ○ Hot flashes
- ○ Breast lump or nipple discharge
- ○ Birth control method if used: _____

Patient Name_____ DOB_____

SEXUAL HISTORY

- ○ Painful intercourse
- ○ Sexually active
- ○ Current sexual partner is Female, Male, or Both (Circle One)
- ○ Use condoms
- ○ Interested in being screened for STD's

PAST MEDICAL HISTORY

Please check all that apply:

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

Other if not listed above:

PAST SURGICAL HISTORY

Surgery	Reason	Date	Location

FAMILY MEDICAL HISTORY

Maternal Grandmother Age: Alive: Y/N	○ Alcoholism	○ Arthritis	○ Cancer (Type):
	○ Depression	○ Diabetes	○ Genetic disease
	○ Heart disease	○ Hypertension	○ Osteoporosis
	○ Stroke	○ Thyroid Disease	○ Other
	○	○	○
Maternal Grandfather Age: Alive: Y/N	○ Alcoholism	○ Arthritis	○ Cancer (Type):
	○ Depression	○ Diabetes	○ Genetic disease
	○ Heart disease	○ Hypertension	○ Osteoporosis
	○ Stroke	○ Thyroid Disease	○ Other
	○	○	○
Paternal Grandmother Age: Alive: Y/N	○ Alcoholism	○ Arthritis	○ Cancer (Type):
	○ Depression	○ Diabetes	○ Genetic disease
	○ Heart disease	○ Hypertension	○ Osteoporosis
	○ Stroke	○ Thyroid Disease	○ Other
	○	○	○
Paternal Grandfather Age: Alive: Y/N	○ Alcoholism	○ Arthritis	○ Cancer (Type):
	○ Depression	○ Diabetes	○ Genetic disease
	○ Heart disease	○ Hypertension	○ Osteoporosis
	○ Stroke	○ Thyroid Disease	○ Other
	○	○	○

Patient Name_____ DOB_____

Mother Age: Alive: Y/N	○ Alcoholism	○ Arthritis	○ Cancer (Type):
	○ Depression	○ Diabetes	○ Genetic disease
	○ Heart disease	○ Hypertension	○ Osteoporosis
	○ Stroke	○ Thyroid Disease	○ Other
	○	○	○
Father Age: Alive: Y/N	○ Alcoholism	○ Arthritis	○ Cancer (Type):
	○ Depression	○ Diabetes	○ Genetic disease
	○ Heart disease	○ Hypertension	○ Osteoporosis
	○ Stroke	○ Thyroid Disease	○ Other
	○	○	○
Sibling Age: Alive: Y/N	○ Alcoholism	○ Arthritis	○ Cancer (Type):
	○ Depression	○ Diabetes	○ Genetic disease
	○ Heart disease	○ Hypertension	○ Osteoporosis
	○ Stroke	○ Thyroid Disease	○ Other
	○	○	○
Sibling Age: Alive: Y/N	○ Alcoholism	○ Arthritis	○ Cancer (Type):
	○ Depression	○ Diabetes	○ Genetic disease
	○ Heart disease	○ Hypertension	○ Osteoporosis
	○ Stroke	○ Thyroid Disease	○ Other
	○	○	○
Other Age: Alive: Y/N	○ Alcoholism	○ Arthritis	○ Cancer (Type):
	○ Depression	○ Diabetes	○ Genetic disease
	○ Heart disease	○ Hypertension	○ Osteoporosis
	○ Stroke	○ Thyroid Disease	○ Other
	○	○	○

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 ○ Occasional ○ Moderate ○ High Level
Caffeine ○ None ○ Occasional ○ Moderate Heavy ○ # of cups/cans per day____	**Alcohol** Do you drink alcohol: Yes or No (Circle One) If so, how often? ○ < 3 times a week ○ >3 times a week How many drinks in one sitting? _____	**Tobacco** Current use Yes or No (Circle One) If not currently, did you ever use tobacco? Yes or No (Circle One) **Current or Former Tobacco Use Habit:** Cigarettes -____pks./day Chew - ____/day Cigars - _____/day # of years____ Or year quit _____
Drugs Current use recreational or street drugs? If yes, list: _____ _____		