Health History Questionnaire

Directions: Please answer all questions as honestly and completely as possible to give your healthcare provider a detailed picture of your health status. If there is not enough room under each question below, additional space is provided at the end.

Date completed _____ / _____ / _____

PAST MEDICAL HISTORY:

Do you have any health problems or injuries for which you regularly take medicines or seek medical attention? **Y N**

Please list below along with approximate date of diagnosis (for example: diabetes - 1996, high blood pressure – 2001)

1) ______________________________
2) ______________________________
3) ______________________________
4) ______________________________
5) ______________________________
6) ______________________________
7) ______________________________
8) ______________________________

How would you rate your present health? **Excellent Good Fair Poor** Is your health status changing? **Y N**

PAST SURGICAL HISTORY:

Have you ever had any operations, or been advised to have one? **Y N** Have you ever been hospitalized? **Y N**

If yes, please list operation or illness and approximate date (for example: gallbladder - 1987, pneumonia – 2003)

1) ______________________________
2) ______________________________
3) ______________________________
4) ______________________________
5) ______________________________
6) ______________________________

MEDICINES:

Please list **all** medicines you take. Include prescription, over-the-counter medicines, supplements, herbs, vitamins, birth control, etc**. Include: medicine name, dosage in mg, how many times per day, and reason for taking.** You may attach a copy of your list instead. Examples: metformin 500 mg, twice daily, diabetes; aspirin 81 mg, once daily, heart)

1) ______________________________
2) ______________________________
3) ______________________________
4) ______________________________
5) ______________________________
6) ______________________________
7) ______________________________
8) ______________________________
9) ______________________________
10) ______________________________
11) ______________________________
12) ______________________________
13) ______________________________
14) ______________________________
15) ______________________________
16) ______________________________
17) ______________________________
18) ______________________________
19) ______________________________
20) ______________________________

Preferred Local Pharmacy

____
Name

____
Address (street & city)

____
Phone#

Mail Order Pharmacy

____
Name

____
Address (street & city)

____
Phone#

Name

ALLERGIES: Have you ever had a reaction to anything, such as medicine, food, insect stings, iodine or latex? **Y N**
If yes, please list the substance that caused the reaction and tell us what happened: (example: penicillin → hives.)

1) ____

2) ____

3) ____

SOCIAL HISTORY / HABITS:

Do you have a regular healthcare provider? **Y N** NowCare provider name ______________________

Other provider ____________________ Clinic Name, location ______________________________

Do you see any specialists? **Y N** List name and reason. ______________________________

____

Marital status ____________ Do you have children? **Y N** Please list age, gender ______________

____

Highest grade completed ________Occupation ____________Employer ____________ Retired? **Y N**

Have you *ever* been a regular tobacco user? **Y N** If yes, circle type **cigarettes cigars pipe chewing tobacco**

Total number of years of present *or* past tobacco use? _____ years Amount per day? ____________

Do you still use tobacco products now? **Y N** If no, when did you quit ____________.

Do you consume alcohol? **Y N** How many drinks of alcohol do you consume per week, on average? ________

Have you or others ever felt that you have a problem with alcohol? **Y N**

Have you used recreational drugs? **Y N** If yes, please list: ______________________________

Have you ever misused prescription drugs such as painkillers? **Y N** If yes, please list: ______________

If yes to any of the above substance use questions, have you ever undergone treatment for dependence or addiction? **Y N**

Do you exercise regularly? **Y N** If yes, how many days per week do you get at least 30-60 minutes of exercise? ____

REVIEW OF SYSTEMS: Please check the box beside any symptom that has bothered you during the past **thirty days.**

General
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fever
- ☐ Night sweats
- ☐ Excess thirst
- ☐ Heat or cold intolerance
- ☐ Heavy snoring
- ☐ Drowsiness or fatigue
- ☐ Exercise intolerance
- ☐ Insomnia
- ☐ Other ______________

Head/Eyes/Ears/Nose/Throat
- ☐ Recurring headaches
- ☐ Visual changes or loss
- ☐ Itchy or watery eyes
- ☐ Dizziness or lightheadedness
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Nosebleeds
- ☐ Runny or stuffy nose
- ☐ Neck pain or stiffness
- ☐ Voice change or loss
- ☐ Sore throat
- ☐ Trouble swallowing

Lungs/Heart/Vascular
- ☐ Cough or wheezing
- ☐ Shortness of breath
- ☐ Chest pain or discomfort
- ☐ Heart palpitations / fluttering
- ☐ Swelling of feet or ankles
- ☐ Pain in legs with exertion
- ☐ Heart murmur

Digestive
- ☐ Abdominal pain
- ☐ Acid reflux
- ☐ Changes in bowel movements
- ☐ Heartburn or indigestion
- ☐ Black or blood in stools
- ☐ Hemorrhoids
- ☐ Appetite changes
- ☐ Nausea or vomiting
- ☐ Hernia or groin pain

Urinary/Reproductive
- ☐ Change in urine color
- ☐ Frequent urination
- ☐ Pregnancy
- ☐ Vaginal discharge
- ☐ Blood in the urine
- ☐ Bladder control problems
- ☐ Burning with urination
- ☐ Waking up to urinate
- ☐ Erectile dysfunction

Name

Orthopedic/Neurologic
- ☐ Joint pain
- ☐ Back or neck pain
- ☐ Weakness in arms or legs
- ☐ Numbness in hands or feet
- ☐ Tingling or burning sensation
- ☐ Back pain
- ☐ Sprains, strains, fractures

Skin/Blood
- ☐ Rashes or other skin changes
- ☐ Changing moles on the skin
- ☐ Itching
- ☐ Excessive sweating
- ☐ Easy Bruising or bleeding

Mental Health
- ☐ Anxiety
- ☐ Depression
- ☐ Memory trouble
- ☐ Problems concentrating
- ☐ Relationship problems
- ☐ Thoughts of suicide
- ☐ Other ________________

PREVENTIVE CARE: Please check the box beside each item if you have had this done and write the year that it was done, if known.

VACCINATIONS:
- ☐ Pneumonia vaccine __________
- ☐ Shingles vaccine ____________
- ☐ Tetanus vaccine ____________
- ☐ Meningitis vaccine __________
- ☐ Hepatitis A vaccine __________
- ☐ Hepatitis B vaccine __________
- ☐ Human papilloma virus vaccine ____________

SCREENING TESTS:
- ☐ Anemia __________________
- ☐ Cholesterol ________________
- ☐ Colonoscopy _______________
- ☐ Diabetes __________________
- ☐ Eye exam _________________
- ☐ Hepatitis __________________
- ☐ HIV ______________________
- ☐ Kidney function ____________
- ☐ Liver function _____________
- ☐ Mammogram ______________
- ☐ PAP smear ________________
- ☐ PSA (prostate) _____________
- ☐ Sexually-transmitted diseases __________________
- ☐ Tuberculosis ______________

FAMILY HISTORY:

Please circle any conditions that have affected any **family members** below and write beside it the relationship to you:

Anemia _____________________
Aneurysm ___________________
Anxiety disorder ______________
Arthritis _____________________
Asthma _____________________
Bipolar______________________
Blood disorder _______________
Cancer _____________________
specify type ________________
Cholesterol problems __________
Dementia ____________________
Depression___________________
Diabetes ____________________
Digestive disorder _____________
Emphysema or COPD _________
Gallbladder problems __________
Gout _______________________
Heart attack _________________
Heart disease ________________
High blood pressure ___________
Kidney disease _______________
Liver disease _________________
Osteoporosis _________________
Seizure disorder ______________
Stroke ______________________
Thyroid problems ____________
Tuberculosis _________________
Vascular disease ______________

Other conditions not listed: ____

____

Please provide any further information here that did not fit in the spaces provided or was not asked but that you feel your healthcare provider needs to know to provide you with the best quality of healthcare.

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I certify that the above information is complete and correct. X ______________________________

Name