Chart code:
Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: *(Last, First, M.I.)*	☐ **M** ☐ **F**	**DOB**

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Doctor: **Date of Last Physical Exam:**

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken Pox ☐ Rheumatic Fever ☐ Polio

Immunizations and Dates:

☐ Tetanus
☐ Hepatitis
☐ Influenza
☐ Pneumonia
☐ Chicken Pox
☐ MMR
Measles, Mumps, Rubella

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries:

Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital

Have you ever had a blood transfusion? ..... ☐ Yes ☐ No

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Name of Drug	Strength	Frequency Taken

Allergies to Medications:

Name of Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Exercise:
☐ Sedentary (No exercise) ☐ Mild Exercise (climb stairs, walk 3 blocks, golf)
☐ Occasional Vigorous Exercise (work or recreation less than 4x/week for 30 min.)
☐ Regular Vigorous Exercise (work or recreation 4x/week for 30 minutes)

Diet:
Do you have a special diet? ..... ☐ Yes ☐ No
What is the reason for your diet? .....

Water:
# of glasses or ounces of water a day: .....

Caffeine:
☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day?

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Alcohol:
Do you drink alcohol? ..... ☐ Yes ☐ No
How many drinks per week? _____
Are you concerned about the amount you drink? ..... ☐ Yes ☐ No

Tobacco:
Do you use tobacco? ..... ☐ Yes ☐ No
☐ Cigarettes - Pks/day ☐ Chew - #/day ☐ Pipe - #/day
☐ Cigars - #/day ☐ # of Years ☐ or Year Quit

Drugs:
Do you currently use recreational or street drugs? ..... ☐ Yes ☐ No
Have you ever given yourself street drugs with a needle? ..... ☐ Yes ☐ No

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Sex:

Are you sexually active? ☐ Yes ☐ No
If yes, are you trying for a pregnancy? ☐ Yes ☐ No
If not trying for a pregnancy, list contraceptive or barrier method used
Any discomfort with intercourse? ☐ Yes ☐ No
Have you ever had any sexually transmitted diseases? ☐ Yes ☐ No
☐Genital Herpes ☐Gonorrhea ☐Syphilis ☐Other

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? ☐ Yes ☐ No

Personal Safety:

Do you live alone? ☐ Yes ☐ No
Do you have frequent falls? ☐ Yes ☐ No
Do you have vision or hearing loss? ☐ Yes ☐ No

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? ☐ Yes ☐ No

FAMILY HEALTH HISTORY

	Age	Age at Death	Significant Health Problems or Cause of Death
Father			
Mother			
Brothers and Sisters	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		

	Age	Age at Death	Significant Health Problems or Cause of Death
Children	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
Grandparents (Mother's Side)			
Male			
Female			
Grandparents (Father's Side)			
Male			
Female			

MENTAL HEALTH

Is stress a major problem for you? ☐ Yes ☐ No
Do you feel depressed? ☐ Yes ☐ No
Do you panic when stressed? ☐ Yes ☐ No
Do you have problems with eating or your appetite? ☐ Yes ☐ No
Do you cry frequently? ☐ Yes ☐ No
Have you ever attempted suicide? ☐ Yes ☐ No
Have you ever seriously thought about hurting yourself? ☐ Yes ☐ No
Do you have trouble sleeping? ☐ Yes ☐ No
Have you ever been to a counselor? ☐ Yes ☐ No

WOMEN ONLY

Age at onset of menstruation: Date of last menstruation:
Period every days. Heavy periods, irregularity, spotting, pain, or discharge? ☐ Yes ☐ No
Number of pregnancies Number of live births
Are you pregnant or breastfeeding? ☐ Yes ☐ No
Have you had a D&C, hysterectomy, or Cesarean section? ☐ Yes ☐ No
Any urinary tract, bladder, or kidney infections within the last year? ☐ Yes ☐ No
Any blood in your urine? ☐ Yes ☐ No
Any problems with control of urination? ☐ Yes ☐ No
Any hot flashes or sweating at night? ☐ Yes ☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? ☐ Yes ☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge? ☐ Yes ☐ No
Have you had vaginal warts? ☐ Yes ☐ No
Date of last pap smear and rectal exam?

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin
☐ Head/Neck
☐ Ears
☐ Nose
☐ Throat
☐ Lungs
☐ Chest/Heart
☐ Back
☐ Intestines
☐ Bladder
☐ Bowels
☐ Circulation

Recent Changes In:

☐ Weight
☐ Energy Level
☐ Ability to Sleep

Other Pain/Discomfort: