

Community Family Medicine

HEALTH HISTORY QUESTIONNAIRE

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

Name <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Chief complaint: (why you are here)			
List any medical problems that other doctors have diagnosed:			
Medications			
List your prescribed medications and over-the-counter medications, such as vitamins and inhalers			
Name the Medication & Strength		Frequency Taken	Reason Taken
Allergies to medications			
Name the Medication		Reaction You Had to Medication	
Who is your Primary Care Physician?			
Would you like to establish with our Practice?			
Health Maintenance		Where was it done?	
Last Complete Physical?			
Last Foot Exam?			
Last Eye Exam?			
Last Dental Exam?			
Last Colonoscopy?		How often do you have them?	
Last Prostate Exam?			
Last Rectal Exam?			
Last Mammogram?			
Last Pap?		Abnormal <input type="checkbox"/> Yes <input type="checkbox"/> No If yes when? _____	

Surgeries		
Year	Reason	Hospital
Other Hospitalizations		
Year	Reason	Hospital
Have you ever had a blood transfusion?		<input type="checkbox"/> Yes Year? <input type="checkbox"/> No
Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cigarettes-Pks./day	<input type="checkbox"/> Chew-#/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars- #/day
_____ Number of years	_____ or year quit	
Alcohol	Do you drink Alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a drink first thing in the morning to steady nerves or get rid of a hangover?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what kind?		
How many drinks per week?		
Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you considered stopping?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever experienced blackouts?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you prone to "binge" drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Family History		
	Age	Significant Health Problems
Father		
Mother		
Siblings		
Children		
Grandparents		
PERSONAL HEALTH HISTORY		

CHILDHOOD ILLNESSES			
MEASLES	<input type="checkbox"/> YES	<input type="checkbox"/> NO	RHEUMATIC FEVER <input type="checkbox"/> YES <input type="checkbox"/> NO
MUMPS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	POLIO <input type="checkbox"/> YES <input type="checkbox"/> NO
CHICKENPOX	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
IMMUNIZATIONS & DATES			
TETANUS			INFLUENZA
HEP A			PNEUMONIA
HEP B			MMR

WOMEN ONLY

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

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, # of times	
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have problems starting or stopping your urine flow	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a weak urine stream?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Health Habits & Personal Safety

Exercise	<input type="checkbox"/> Sedentary (no exercise)
	<input type="checkbox"/> Mild Exercise (climb stairs, walk 3 blocks, golf)
	<input type="checkbox"/> Occasional vigorous exercise (work or recreation, less than 4x/week for 30 min.)
	<input type="checkbox"/> Regular vigorous exercise (work or recreation 4x/week for 30 min)

Diet	Are you dieting? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes, are on a physician prescribed medical diet? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	# of meals you eat in an average day? _____		
	Body Mass Index? _____		
	Rank Salt Intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med <input type="checkbox"/> Low
	Rank Fat Intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med <input type="checkbox"/> Low
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea <input type="checkbox"/> Cola
	# of cups per day? _____		
Sex	Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Are you sexually active with <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both How may partners? _____		
	If yes are you trying for a pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If not trying for a pregnancy list contraceptive or barrier method used: _____		
	Any discomfort with intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Illness related to 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Personal Safety	Do you live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Do you have a physical handicap? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Do you have frequent falls? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Do you have vision or hearing loss? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Do you feel safe at home? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Do you use a seat belt? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Physical and/or mental abuse has also been 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Mental Health	Is stress a major problem for you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Do you feel depressed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Do you panic when stressed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Do you have problems with eating or your appetite? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Do you cry frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Have you ever attempted suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Have you ever seriously thought about hurting yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Do you have trouble sleeping? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Have you ever been to a counselor? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Have you ever thought about harming someone else? <input type="checkbox"/> Yes <input type="checkbox"/> No		