

HEALTH HISTORY QUESTIONNAIRE

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

1. _____
2. _____
3. _____

REACTION

- _____
- _____
- _____

FAVORITE PHARMACY MEDICATIONS

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

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

IMMUNIZATION HISTORY

Immunizations and most recent date:

- | | | | |
|---------------------------------------|-------------|---|-------------|
| <input type="checkbox"/> Chickenpox | Date: _____ | <input type="checkbox"/> Meningococcus | Date: _____ |
| <input type="checkbox"/> Flu Shot | Date: _____ | <input type="checkbox"/> MMR (<i>Measles, Mumps, Rubella</i>) | Date: _____ |
| <input type="checkbox"/> Gardasil/HPV | Date: _____ | <input type="checkbox"/> Pneumonia | Date: _____ |
| <input type="checkbox"/> Hepatitis A | Date: _____ | <input type="checkbox"/> Tdap (<i>Tetanus and pertussis</i>) | Date: _____ |
| <input type="checkbox"/> Hepatitis B | Date: _____ | <input type="checkbox"/> Tetanus | Date: _____ |
| | | <input type="checkbox"/> Zostavax (<i>Shingles</i>) | Date: _____ |

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ Abnormal

Last Mammogram Date _____ Abnormal

Age of first menstrual period: _____

Date of last menstrual period or age of menopause: _____

Number of pregnancies: _____ births: _____

miscarriages: _____ abortions: _____

Cesarean sections If yes, then number: _____

Current sexual partner is Female Male

Do you use condoms Yes No

Other Birth control method used: _____

Interested in being screened for STD's

- Bleeding between periods
- Heavy periods
- Extreme menstrual pain
- Vaginal itching, burning, or discharge
- Wake in the night to go to the bathroom
- Hot flashes
- Breast lump or nipple discharge
- Painful intercourse
- Sexually active

PAST MEDICAL HISTORY

Please check all that apply:

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

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1. _____	_____	_____	_____
1. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Grandfather (maternal)	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Grandmother (paternal)	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Grandfather (paternal)	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Father	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Mother	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Brother/Sister	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Brother/Sister	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke
Other: _____	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke

SOCIAL HISTORY

Education <input type="checkbox"/> Less than 8th grade <input type="checkbox"/> High school <input type="checkbox"/> 2 year college <input type="checkbox"/> 4 year college <input type="checkbox"/> Post graduate	Caffeine <input type="checkbox"/> None <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy # of cups/cans per day? _____	If not currently, did you ever use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No Cigarettes - ___pks/day Chew - ___/day Cigars - ___/day #of years ___Or year quit _____
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic partner	Alcohol Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how often? <input type="checkbox"/> Occasionally <input type="checkbox"/> < 3 times a week <input type="checkbox"/> > 3 times a week How Many Drinks per Week _____	Drugs Do you currently use recreational or street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list: _____
Exercise Level <input type="checkbox"/> None (No exercise) <input type="checkbox"/> Occasional exercise <input type="checkbox"/> Moderate exercise <input type="checkbox"/> High level exercise	Tobacco Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	

REVIEW OF SYSTEMS

<p>Please check all that apply:</p> <p>Allergic/Immunologic</p> <p><input type="checkbox"/> Frequent Sneezing</p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Runny Nose</p> <p><input type="checkbox"/> Sinus Pressure</p> <p>Cardiovascular</p> <p><input type="checkbox"/> Arm Pain on Exertion</p> <p><input type="checkbox"/> Chest Pain on Exertion</p> <p><input type="checkbox"/> Chest Heaviness/Pressure on Exertion</p> <p><input type="checkbox"/> Irregular Heart Beats (Palpitations)</p> <p><input type="checkbox"/> Known Heart Murmur</p> <p><input type="checkbox"/> Light-headed on Standing</p> <p><input type="checkbox"/> Shortness of Breath When Lying Down</p> <p><input type="checkbox"/> Shortness of Breath When Walking</p> <p><input type="checkbox"/> Swelling (edema)</p> <p>Constitutional</p> <p><input type="checkbox"/> Exercise Intolerance</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Weight Gain (___lbs)</p> <p><input type="checkbox"/> Weight Loss (___lbs)</p> <p>Eyes</p> <p><input type="checkbox"/> Dry Eyes</p> <p><input type="checkbox"/> Irritation</p> <p><input type="checkbox"/> Vision Change</p> <p>Date of Last Exam: _____</p>	<p>Ears/Nose/Mouth/Throat</p> <p><input type="checkbox"/> Bleeding Gums</p> <p><input type="checkbox"/> Difficulty Hearing</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Dry Mouth</p> <p><input type="checkbox"/> Ear Pain</p> <p><input type="checkbox"/> Frequent Infections</p> <p><input type="checkbox"/> Frequent Nosebleeds</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Mouth Breathing</p> <p><input type="checkbox"/> Mouth Ulcers</p> <p><input type="checkbox"/> Nose/Sinus</p> <p><input type="checkbox"/> Problems Ringing in Ears</p> <p><input type="checkbox"/> Endocrine</p> <p><input type="checkbox"/> Fatigue Increased</p> <p><input type="checkbox"/> Thirst/Hunger/Urination</p> <p>Gastrointestinal</p> <p><input type="checkbox"/> Abdominal Pain</p> <p><input type="checkbox"/> Black or Tarry Stool</p> <p><input type="checkbox"/> Blood in Stool</p> <p><input type="checkbox"/> Change in Appetite</p> <p><input type="checkbox"/> Frequent Indigestion</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Trouble Swallowing</p> <p>Vomiting</p> <p><input type="checkbox"/> Vomiting Blood</p>	<p>Genitourinary</p> <p><input type="checkbox"/> Blood in Urine</p> <p><input type="checkbox"/> Difficulty Urinating</p> <p><input type="checkbox"/> Incomplete Emptying</p> <p><input type="checkbox"/> Increased Urinary Frequency</p> <p><input type="checkbox"/> Urinary Loss of Control</p> <p>Hematologic/Lymphatic Easy</p> <p><input type="checkbox"/> Bruising/Bleeding Swollen Glands</p> <p>Integumentary (Skin)</p> <p><input type="checkbox"/> Changes in Moles</p> <p><input type="checkbox"/> Dry Skin</p> <p><input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> Growth/Lesion</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Jaundice (Yellow Skin/Eyes)</p> <p><input type="checkbox"/> Rash</p> <p>Musculoskeletal</p> <p><input type="checkbox"/> Back Pain</p> <p><input type="checkbox"/> Joint Pain</p> <p><input type="checkbox"/> Muscle Aches</p> <p><input type="checkbox"/> Muscle Weakness</p>	<p>Neurological</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Memory Loss</p> <p><input type="checkbox"/> Migraines</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Restless Legs</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Weakness</p> <p>Psychiatric</p> <p><input type="checkbox"/> Alcohol Overuse</p> <p><input type="checkbox"/> Anxiety/Stress</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Do Not Feel Safe in Relationship</p> <p><input type="checkbox"/> Mania</p> <p><input type="checkbox"/> Sleep Problems</p> <p>Respiratory</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Coughing Up Blood</p> <p><input type="checkbox"/> Shortness of Breath</p> <p><input type="checkbox"/> Sleep Apnea</p> <p><input type="checkbox"/> Snoring</p> <p><input type="checkbox"/> Wheezing</p>
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Please add any other information about your health that you would like your provider to know here:

Parent, Guardian, or Caregiver Signature

Date