

Original Date:

3/8/2004

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

Previous or Referring 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

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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

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
 Do you have an Advance Directive and/or Living Will? Yes No
 Would you like information on the preparation of these? 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

Please remember that the following recommendations are very important to maintaining your health.

When in a car, wear your safety belt at all times.

While riding a motorcycle or bicycle, wear a helmet.

Always have functional smoke detectors and fire extinguishers in your home.

If you own a firearm, make sure that it is accessible only to you. Take every precaution to ensure that children do not have access to a loaded firearm.

Keep the firearm and ammunition in separate locations.

FAMILY HEALTH HISTORY

	Age	Age at Death	Significant Health Problems or Cause of Death		Age	Age at Death	Significant Health Problems or Cause of Death
Father				Children	<input type="checkbox"/> M <input type="checkbox"/> F		
Mother					<input type="checkbox"/> M <input type="checkbox"/> F		
Brothers and Sisters	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandparents (Mother's Side)			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Male</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Female</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandparents (Father's Side)			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Male</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Female</i>			

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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
- Date of last pap smear and rectal exam?

MEN ONLY

- Do you usually get up to urinate during the night? Yes No If yes, # of times
- Do you feel pain or burning with urination? Yes No
- Any blood in your urine? Yes No
- Do you feel burning discharge from penis? Yes No
- Has the force of your urination decreased? Yes No
- Have you had any kidney, bladder, or prostate infections within the last 12 months? Yes No
- Do you have any problems emptying your bladder completely? Yes No
- Any difficulty with erection or ejaculation? Yes No
- Any testicle pain or swelling? Yes No
- Date of last prostate 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:**