HEALTH HISTORY QUESTIONNAIRE

Name:_____ DOB:_____ □M □F

Previous or referring doctor: Date of last physical exam:

Health History **:** Please mark any of the following that apply

□High blood pressure □Heart disease □High cholesterol □Diabetes type 1 □Diabetes type 2 □Cancer - type:_____

□Hypothyroidism □Hyperthyroidism □Migraine headaches □Seizures or convulsions □Stroke □Glaucoma □Cataracts

□Blindness □Deafness □Asthma □Heart attack □Arthritis □Serious depression □Ovarian Cyst(s) □Other_____

Infection History*:* Please mark any of the following that apply

□Chicken Pox □Measles □Mumps □Polio □Hepatitis A □Hepatitis B □Hepatitis C □HIV

□HPV □STD's □MRSA □Meningitis □UTI's(frequent) □Shingles □ Genital Herpes

□Rash/viral illness since last LMP □exposed to TB □Vaccinated for TB □HX abnormal TB test □Other_____

Surgical History: Surgery Year Surgery Year

_____

_____

_____

Women only - Date of last: Mammogram_____ DEXA_____

Colonoscopy_____ Performed by:_____

LMP_____ PAP_____ HX of Abnormal Pap Y or N - Results:_____ Year:_____

Men only -

Date of last: Prostate/rectal exam_____ Colonoscopy_____ Performed by: _____

Family History:

Relationship/Name	Birth date	Death date	Disease/Significant Health Problem(s) - Cause of Death
Mother:			
Father:			
Mat. Gma:			
Mat. Gpa:			
Pat. Gma:			
Pat. Gpa:			
Brother or Sister:			
Brother or Sister:			
Brother or Sister:			
Children: Son / Daughter			
Children: Son / Daughter			
Children: Son / Daughter			

Medication History: List prescribed and over-the-counter drugs (vitamins, inhalers etc)

Name of medication	Strength	Frequency taken

Social History:	
Marital status	□Single □Partnered □Married □Separated □Divorced □Widowed □Remarried
Sexual history	□Multiple sex partners □Prefer opposite sex □Prefer same-sex partner
# of children	_____
# children in household	_____
# adults in household	_____
Living arrangements	□House □Apt/Condo/Townhome □Trailer □Care Facility □Homeless □Other
Education level	□Grade □Some HS □HS graduate □Some college □College grad □Post-grad
Employment	□Employed □Unemployed □Retired □Student
Tobacco use	□Nonsmoker □Current smoker □Former smoker □Smokeless tobacco user
# years using tobacco	_____ Age started:
# cigarette's/day	□1/4 pack (5) □1/2 pack (10) □1 pack (20) □1 1/2 packs (30) □2 packs (40)
Alcohol use	□Never □Seldom □Social □Currently drinks □Quit this year
# years drinking	_____ Age started:
Frequency of drinks	□1-4/wk □7/wk □10/wk □14/wk □2+/day □Drinks rarely
History of illegal drug use	□Never □Currently □Quit less than 3 years ago □In the past only
# years using drugs	_____ Age started:
Caffiene - cups/day	□YES □NO □Cups/day _____
Tattoos	□YES □NO □Were they done professionally? _____
Other	

Medication Allergies **: Name of drug**	Reaction you had

Food Allergies: **Name of food**	Reaction you had

Environmental Allergies **- for example: Latex, iodine, tapes, bees, seasonal etc.**	
Type	Reaction you had

Immunization History*:*
Current Vaccinations? Yes/No
Last Immunization:

Other services: Please mark any of the following that apply

□None□Cane □Colostomy □CPAP/APAP □Dialysis □Foley Catheter □Pacemaker □Nebulizer □Hearing aides

□Blood transfusion □Home Glucometer □Oxygen □PEG tube □Portacath □Suprapubic catheter

□Walker □Wheelchair □Other providers seeing:_____