

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: \_\_\_\_\_  M  F      DOB: \_\_\_/\_\_\_/\_\_\_  
 (Last, First, M.I.)

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    Chickenpox    Rheumatic Fever    Polio

Immunizations and Dates:    Tetanus \_\_\_\_\_       Pneumonia \_\_\_\_\_  
     Hepatitis \_\_\_\_\_       Chickenpox \_\_\_\_\_  
     Influenza \_\_\_\_\_       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





## 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? .....  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 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 \_\_\_\_\_
- Intestinal \_\_\_\_\_
- Bladder \_\_\_\_\_
- Bowel \_\_\_\_\_
- Circulation \_\_\_\_\_
- Recent Changes In:**
- Weight \_\_\_\_\_

- Energy Level \_\_\_\_\_
- Ability to Sleep \_\_\_\_\_
- Other Pain/Discomfort:**
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



**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

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
<b>Father</b>				<b>Children</b>	<input type="checkbox"/> M <input type="checkbox"/> F		
<b>Mother</b>					<input type="checkbox"/> M <input type="checkbox"/> F		
<b>Brothers and Sisters</b>	<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			<b>Grandparents (Mother's Side)</b>			
	<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			<b>Grandparents (Father's Side)</b>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Male</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Female</i>			

## Review of Systems

Check the lines under negative if there is not a problem with anything in that category, otherwise circle what applies.

### NEGATIVE

- \_\_\_\_\_ 1. *CONSTITUTIONAL - Weight Loss*
- \_\_\_\_\_ 2. *EYES – Diplopia, Eye Pain, Blurry Vision*
- \_\_\_\_\_ 3. *EARS, NOSE, MOUTH, & THROAT – Hearing Loss, Mouth Ulcers, Recurrent Sore Throat*
- \_\_\_\_\_ 4. *CARDIOVASCULAR – Chest Pain, Prior Cardiac Surgery, Swollen Legs, Irregular Heart Beat, Shortness of Breath*
- \_\_\_\_\_ 5. *RESPIRATORY – Use Oxygen, Asthma, Shortness of Breath*
- \_\_\_\_\_ 6. *SKIN – Rash, Changing Moles, Skin Lesions*
- \_\_\_\_\_ 7. *MUSCULOSKELETAL – Swollen or Still Joints, Attending Physical Therapy, Lumps on Bone, Weakness*
- \_\_\_\_\_ 8. *NEUROLOGICAL – Balance Problems, Speech Problems, Prior Strokes*
- \_\_\_\_\_ 9. *GASTROINTESTINAL – Jaundice, Nausea, Vomiting, Abdominal Pain*
- \_\_\_\_\_ 10. *GENITOURINARY - Kidney Trouble, Blood in Urine, Difficulty Urinating*
- \_\_\_\_\_ 11. *ENDOCRINE – Diabetes, Cold or Heat Intolerance*
- \_\_\_\_\_ 12. *PSYCHIATRIC – Confusion, Violent Behavior, Decreased Self-esteem*
- \_\_\_\_\_ 13. *HEMATOLOGIC-LYMPHATIC – Swollen Glands, Fatigue, Easy Bruising, Free Bleeding*