Please print, fill in, and bring with you for your office visit

Today's Date:

INITIAL 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 **Date of Birth:**

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of children: **Age Range of Children:**

Previous or referring doctor:

Reason for visit:

PERSONAL HEALTH HISTORY

List all medications and supplements taken regularly

Name the Drug or Supplement	Taken for:	Dose (strength and frequency)	Prescribed by: (write "Self" if self-prescribed)

Do you have any known allergies to medications? ☐ Yes ☐ No If yes, please fill out chart below.

Name the Drug	Reaction You Had

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Other:

Immunizations: (Please indicate dates.)

☐ Tetanus:	☐ Pneumonia:
☐ Hepatitis A:	☐ Chickenpox:
☐ Hepatitis B:	☐ HPV:
☐ Influenza:	☐ MMR: Measles, Mumps, Rubella

Screening Exams: Please indicate the date of your last exam and whether it was normal.

Exam	**Date**	**Result**	**Exam**	**Date**	**Result**
Cholesterol		☐ Normal ☐ Abnormal	Hemoccult/Blood in stool		☐ Normal ☐ Abnormal
Colonoscopy		☐ Normal ☐ Abnormal	Mammogram (women)		☐ Normal ☐ Abnormal
DEXA/Bone Scan		☐ Normal ☐ Abnormal	PAP (women)		☐ Normal ☐ Abnormal
Dental		☐ Normal ☐ Abnormal	Physical Exam		☐ Normal ☐ Abnormal
Eye Exam		☐ Normal ☐ Abnormal	Prostate (men)		☐ Normal ☐ Abnormal
Glucose/Blood Sugar		☐ Normal ☐ Abnormal	TB Screening		☐ Normal ☐ Abnormal

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Hospitalizations		**Surgeries**	
Year	Reason	Year	Reason

List any medical problems that other doctors have diagnosed

FAMILY HEALTH HISTORY

Please place an "X" in the relevant boxes.

Condition:	Mother	Father	Sibling	Grandparent (maternal)	Grandparent (paternal)
Alcoholism					
Autoimmune					
Cancer (specify type)					
Diabetes					
Heart Disease					
High cholesterol					
Hypertension					
Mental Illness					
Migraine					
Multiple Sclerosis					
Osteoporosis					
Seizures					
Stroke					
Thyroid					

HEALTH HABITS AND PERSONAL SAFETY

Alcohol

Do you drink alcohol? ☐ Yes ☐ No If yes, indicate type and how many drinks per week:

Are you concerned about the amount you drink? ☐ Yes ☐ No

Have you considered stopping? ☐ Yes ☐ No

Have you ever experienced blackouts? ☐ Yes ☐ No

Are you prone to "binge" drinking? ☐ Yes ☐ No

Do you drive after drinking? ☐ Yes ☐ No

Caffeine

☐ None ☐ Coffee ☐ Tea ☐ Cola/Soda

# of cups/cans per day?

Diet

Do you follow a special diet? ☐ Yes ☐ No If yes, specify:

Do you avoid any foods? ☐ Yes ☐ No If yes, specify:

How much water do you drink per day? Is it filtered water? ☐ Yes ☐ No ☐ Sometimes

Please list the typical foods you eat for:

Breakfast:

Lunch:

Dinner:

Snacks:

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Exercise	☐ Sedentary (No exercise)		
	☐ Mild exercise (for example, climbing stairs, walking 3 blocks, golf)		
	☐ Occasional vigorous exercise (for example, work or recreation, less than 4x/week for 30 min.)		
	☐ Regular vigorous exercise (for example, work or recreation 4x/week for 30 minutes or more)		
Sleep	Do you have trouble falling asleep?	☐ Yes	☐ No
	Do you wake during the night?	☐ Yes	☐ No
	If yes, do you have trouble falling back asleep?	☐ Yes	☐ No
	Do you wake feeling rested?	☐ Yes	☐ No
	Average number of hours of sleep:		
	Rate your current energy on a scale of 1-10 (10=highest):		
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	Cigarettes or other form – amt./day: # of years: Or year quit:		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Sex	Are you currently sexually active? ☐ Yes ☐ No Gender of sexual partner(s): ☐Female	☐ Male	☐ Both
	Have you been sexually active in the past? ☐ Yes ☐ No Gender of sexual partner(s): ☐Female	☐ Male	☐ Both
	Are you trying for a pregnancy?	☐ Yes	☐ No
	If you are not trying for a pregnancy, list contraceptive or barrier method used:		
	Any problems or concern with sexual function or desire?	☐ Yes	☐ No
	Illness related to Human Immunodeficiency Virus (HIV), such as AIDS, have become a major public health problem. Risk factors for this illness include IV 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 wear your seat belt? ☐ Yes ☐ No / Do you wear your helmet?	☐ Yes	☐ No
	Do you avoid excess UV exposure or wear sunscreen?	☐ Yes	☐ No
	Is the battery current in your smoke detector?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of an Advanced Directive or Living Will?	☐ Yes	☐ No
	Physical and/or mental abuse has 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

MENTAL HEALTH		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed or cry frequently?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Have you intentionally harmed yourself?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Have you ever seriously thought about hurting others?	☐ Yes	☐ No
Do you feel you have an adequate support system?	☐ Yes	☐ No
Are you currently seeing a counselor? ☐ Yes ☐ No If so, who?		

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Review of systems: Mark "C" for current problems; For problems in the past, please write the YEAR it occurred.					
Current? Past? (Write Date)	**Allergic/Immunologic**	Current? Past? (Write Date)	**Ears, Nose, Mouth, Throat (cont.)**	Current? Past? (Write Date)	**Hematological**
	Arthritic flare-up		Epistaxis (nosebleeds)		Anemia
	Hay fever symptoms		Hoarseness		Bruise Easily
	Cardiovascular		Hypoglycemia		**Musculoskeletal**
	Ankle swelling		Ringing in ear		Back pain (chronic)
	Chest pain		Sinus problem		Foot pain
	Elevated blood pressure		Sore throat		Gout attack
	Fatigue		**Eyes**		Leg pain
	Irregular heartbeat		Blurred Vision		Neck pain
	Murmur (heart)		Loss of vision		**Neurological**
	Palpitations		Pain or soreness in or about the eyes		Difficulty concentrating
	Shortness of breath at rest		**Gastrointestinal**		Dizziness
	Shortness of breath in the night		Abdominal pain		Headache
	Shortness of breath with exercise		Blood in stool		Numbness
	Syncope (fainting)		Constipation		Seizures
	Varicose veins		Diarrhea		Tingling
	Dermatologic (Skin)		Heartburn		Tremors
	Eczema		Hemorrhoids		**Psychiatric**
	Hives		Loss of appetite		Anxiety
	Pruritis (itching)		Melena (dark, tarry stools)		Depression
	Psoriatic flare-up		Nausea		Insomnia
	Rash		Swallowing difficulty		Memory Loss
	Endocrine		Vomiting		Mood changes
	Cold intolerance		Weight gain		**Respiratory**
	Dry Skin		Weight loss, unintentional		Asthma
	Excess hair growth		Yellowing of skin		Cough
	Extreme thirst		**Genitourinary**		Wheezing
	Hyperglycemia		Discharge (from urethra)		Shortness of breath
	Thyroid disease		Painful urination		
	Unusual fatigue		Urinary difficulty		**Other? Please explain:**
	Ears, Nose, Mouth, Throat		Urinary incontinence		
	Cough, chronic		Urinary output low		
	Difficulty with hearing		Urinating frequently at night		
	Ear infection				

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WOMEN ONLY

Age at onset of menstruation:		
First day of last menstrual period: _____/_____/_______ Number of days of flow:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____ Number of Miscarriages _____		
Are you pregnant or breastfeeding?	☐ 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
Have you been instructed on breast self-exams?	☐ Yes	☐ No
Do you regularly do breast self-exams?	☐ Yes	☐ No

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
Have you been instructed on testicular self-exams?	☐ Yes	☐ No
Do you regularly do testicular self-exams?	☐ Yes	☐ No

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