	a series possession to		
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.):					4 🗆	1 🗆 FDate	of Birth:
Marital status: ☐ Single	e □ Pa	artnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowe	ed
Number of children:			Age	Range of Ch	ildren:		
Previous or referring o	loctor:						
Reason for visit:							
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			PERS	ONAL HEAL	TH HISTOR	RY	
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List all medications an	d suppl	ements	taken regulari	1			
Name the Drug or Supplement		ş 3	Taken for:		Dose (strengt frequency)	th and	Prescribed by: (write "Self" if self- prescribed)
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Do you have any know	n aller	ies to m	edications?	Yes □ No	If ves nleas	e fill out char	t helow
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Childhood illness: 🗆 M	leasles	☐ Mump	os 🗆 Rubella	☐ Chickenpo	x 🗆 Rheum	atic Fever	□ Polio □ Other:
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DEXA/Bone Scan		□ Norm	al 🗆 Abnormal	PAP (wome	n)	·	□ Normal □ Abnormal
Dental		□ Norm	al 🗆 Abnormal	Physical Exa	ım		☐ Normal ☐ Abnormal
Eye Exam		□ Norm	al 🗆 Abnormal	Prostate (m	en)	A CONTRACTOR OF A MINE	□ Normal □ Abnormal
Glucose/Blood Sugar	makan kanala ak akana.	□ Norm	al 🗆 Abnormal	TB Screenin	<b>g</b>		□ Normal □ Abnormal
1 of 5				Patient Name:			DOB:

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

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Are you prone to "binge" drinking?  Do you drive after drinking?  None		,				. C	Yes □ No
Do you drive after drinking?		jern 1 man 1 man 2 m 1 m 1 m 1 m 1 m 1 m 1 m 1 m 1 m 1 m	And the second control of the second control		recommender of the control of the co		Yes □ No
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Lunch: Dinner: Snacks:			ypical foods you eat for	:			
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Snacks:		Lunch:					
		Dinner:					
		Snacks:					
							_

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

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
a	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):				entrantament entrantament
Tobacco	Do you use tobacco?		Yes		No
	Cigarettes or other form – amt./day: # of years: Or year quit:	and the state of the		adan , ra an, ra aran	and the second section of the second
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:		Mandredon Avantaires en en entre	arterne navarna ne	•
	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	; <b>-</b>	No
Personal	Do you live alone?		Yes	; <b>□</b>	No
Safety	Do you have frequent falls?		Yes		No
:	Do you have vision or hearing loss?		Yes		No
	Do you wear your seat belt? ☐ Yes ☐ Yes ☐ No		Yes		No
	Do you avoid excess UV exposure or wear sunscreen?		Yes		No
	Is the battery current in your smoke detector?		Yes	; <b></b>	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	, 0	No
4 4	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
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MENTAL HE					
	major problem for you?		Yes		No
	depressed or cry frequently?		Yes		No
	ic when stressed?		Yes		No
	re problems with eating or your appetite?		Yes	. 🗆	No
Have you i	ntentionally harmed yourself?		Yes		No
I	ver seriously thought about hurting yourself?		Yes		No
	ever seriously thought about hurting others?		Yes		No
Do you fee	you have an adequate support system?		Yes	. 🛮	No
Are you cu	rrently seeing a counselor?  Yes No If so, who?			. Indica - Indicada W	
3 of 5	Patient Name:	DOE	3:		



rrent? t? (Write Date)	Allergic/Immunologic	Past? (write Pate)	Ears, Nose, Mouth, Throat (cont.)	Current? Past? (Write Hematological Date)	
	Arthritic flare-up		Epistaxis (nosebleeds)	Anemia	
	Hay fever symptoms	More and a second	Hoarseness	Bruise Easily	
	Cardiovascular	er vice description	Hypoglycemia	Musculoskeletal	
	Ankle swelling	eserciones de la company de la	Ringing in ear	Back pain (chronic)	
	Chest pain	300	Sinus problem	Foot pain	
	Elevated blood pressure	94	Sore throat	Gout attack	
	Fatigue	obidiems/ soil o	Eyes	Leg pain	
	Irregular heartbeat	Cherechipellands	Blurred Vision	Neck pain	
ACI-CARACIAMATE COMO BON	Murmur (heart)		Loss of vision	Neurological	
	Palpitations		Pain or soreness in or about the eyes	Difficulty concentration	ng
anna manna mana	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	ar andreas
months made in a dist	Syncope (fainting)		Constipation	Seizures	
	Varicose veins		Diarrhea •	Tingling	
	Dermatologic (Skin)		Heartburn	Tremors	t the effective Section 1
	Eczema		Hemorrhoids	Psychiatric	
den en e	Hives		Loss of appetite	Anxiety	
and of models do	Pruritis (itching)		Melena (dark, tarry stools)	Depression	
eriti e Peredenti edelikultur tudiketek 1	Psoriatic flare-up		Nausea	Insomnia	
	Rash		Swallowing difficulty	Memory Loss	
	Endocrine		Vomiting	Mood changes	
	Cold intolerance		Weight gain	Respiratory	en remova
A 11415110	Dry Skin	-	Weight loss, unintentional	Asthma	
	Excess hair growth		Yellowing of skin	Cough	
	Extreme thirst		Genitourinary	Wheezing	and among the Visit of
	Hyperglycemia		Discharge (from urethra)	Shortness of breath	
- / /	Thyroid disease	The second secon	Painful urination		
	Unusual fatigue	**************************************	Urinary difficulty	Other? Please expl	ain:
TO AN THE STREET OF STREET SE	Ears, Nose, Mouth, Throat		Urinary incontinence		
	Cough, chronic		Urinary output low		
	Difficulty with hearing		Urinating frequently at night		

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

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?	<sup>r</sup> □ 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?	<sup>2</sup> □ 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

Patient Name:\_



DOB:\_