

**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.):					ΩF	□MDat	e of Birth:
Marital status: ☐ Sing	gle 🗆	Partnered	☐ Married	□ Separated	☐ Divorced	□ Widov	ved
Number of children:		OFFICE A PERSON OF THE PROPERTY OF THE PROPERT	Age	Range of Ch	ildren:	***************************************	
Previous or referring	docto	r:	The second secon	THE RESIDENCE OF THE PARTY OF T	ner all tree i Sandiden editor anna dell'Alexa e conserva		SOUTHWATER WATER TO THE PARTY OF THE PARTY O
Reason for visit:					ene met voj journojn jugostojn aj esperjente propagostojn metanoj en moj	eyeppener or you are consistent and an account	
	the territories are again appropriate				· · · · · · · · · · · · · · · · · · ·		
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	·					man a street of manufacturing the most of the state of th	
List all medications a	and sup	plements	taken regular	ly	Dose (strengt	h and	Prescribed by: (write "Self" if self-
Name the Drug or Supp	olement		Taken for:		frequency)		prescribed)
					;		
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			:				:
Do you have any kno	wn alle	eraies to m	edications? (	□ Yes □ No	If ves. please	e fill out cha	art below.
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garanta a managaran garan sa	wn alle		Annual management and an array of the second	resource is a series around a selec-	If yes, please	e fill out cha	art below.
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garanta a managaran garan sa	own allo		Annual management and an array of the second	resource is a series around a selec-	If yes, please	e fill out cha	art below.
Name the Drug			Reaction You H	resource is a series around a selec-		LA MATERIAN PROPERTY APPE	□ Polio □ Other:
Name the Drug  Childhood illness:   Immunizations: (Ple	Measle	s 🗆 Mump	Reaction You H	lad	x □ Rheuma	LA MATERIAN PROPERTY APPE	□ Polio □ Other:
Name the Drug  Childhood illness:   Immunizations: (Ple	Measle	s	Reaction You H	lad	x □ Rheuma	atic Fever □ Pneumoi	□ Polio □ Other:
Name the Drug  Childhood illness:  Immunizations: (Ple	Measle:	s □ Mump Tetanus: Hepatitis A:	Reaction You H	lad	x Rheuma	atic Fever	□ Polio □ Other:
Name the Drug  Childhood illness:  Immunizations: (Ple	Measle:	s □ Mump Tetanus: Hepatitis A: Hepatitis B:	Reaction You H	lad	x □ Rheuma	atic Fever  Pneumoi Chickenp HPV: MMR:	□ Polio □ Other: nia: pox:
Name the Drug  Childhood illness:  Immunizations: (Pleindicate dates.)	Measle:	s	Reaction You H	□ Chickenpc	x  Rheuma	atic Fever  Pneumoi Chickenp HPV: MMR: Measles, Mump	□ Polio □ Other: nia: DOX:
Name the Drug  Childhood illness:  Immunizations: (Pleindicate dates.)  Screening Exams: Pl	Measle:	s	Reaction You H	☐ Chickenpo	x  Rheuma	atic Fever  Pneumon Chickenp HPV: HPW: Measles, Mump	□ Polio □ Other: nia: pox:
Name the Drug  Childhood illness:  Immunizations: (Pleindicate dates.)  Screening Exams: Pleixam	Measle:	s	Reaction You H	□ Chickenpo	x Rheuma	atic Fever  Pneumoi Chickenp HPV: MMR: Measles, Mump	□ Polio □ Other: nia: DOX:  Pos, Rubella
Name the Drug  Childhood illness:  Immunizations: (Pleindicate dates.)  Screening Exams: Pleindicate Cholesterol	Measle:	s	Reaction You H	□ Chickenpo	x □ Rheuma  I whether it v	atic Fever  Pneumon Chickenp HPV: HPW: Measles, Mump	□ Polio □ Other: nia: pox: ps, Rubella nl. Result □ Normal □ Abnormal
Name the Drug  Childhood illness:  Immunizations: (Pleindicate dates.)  Screening Exams: Pleindicate Colonoscopy	Measle:	s	Reaction You H	□ Chickenpo  Chickenpo  Exam  Hemoccuit/ Mammograi	Rheuma  I whether it was a second in stool m (women)	atic Fever  Pneumon Chickenp HPV: HPW: Measles, Mump	□ Polio □ Other: nia: DOX: DOX:  Result □ Normal □ Abnormal □ Normal □ Abnormal
Name the Drug  Childhood illness:  Immunizations: (Pleindicate dates.)  Screening Exams: Plexam  Cholesterol  Colonoscopy  DEXA/Bone Scan	Measle:	s	Reaction You H  Reaction You H  Rubella  Abnorma  Abnorma  Abnorma	Chickenpo  Chickenpo  Exam  Hemoccult/ Mammograi	Rheuma  I whether it was a stool man (women)  n)	atic Fever  Pneumon Chickenp HPV: HPW: Measles, Mump	Polio    Other: nia: pox:  pos, Rubella nil.  Result     Normal    Abnormal     Normal    Abnormal     Normal    Abnormal
Name the Drug  Childhood illness:  Immunizations: (Pleindicate dates.)  Screening Exams: Pl Exam Cholesterol Colonoscopy DEXA/Bone Scan Dental	Measle:	s	Reaction You H  Reaction You H  Rubella  Abnorma  Abnorma  Abnorma	□ Chickenpo  Cast exam and Exam  Hemoccult/ Mammograt PAP (women Physical Exam	I whether it v  Blood in stool m (women) n)	atic Fever  Pneumon Chickenp HPV: HPW: Measles, Mump	□ Polio □ Other: nia: pox: ps, Rubella nil. Result □ Normal □ Abnormal □ Normal □ Abnormal □ Normal □ Abnormal □ Normal □ Abnormal
Do you have any knot Name the Drug  Childhood illness:  Immunizations: (Ple indicate dates.)  Screening Exams: Ple Exam  Cholesterol  Colonoscopy  DEXA/Bone Scan  Dental  Eye Exam  Glucose/Blood Sugar	Measle:	s	Reaction You H  Reaction You H  Rubella  Abnorma  Abnorma  Abnorma	Chickenpo  Chickenpo  Exam  Hemoccult/ Mammograi PAP (wome	I whether it was a second of the second of t	atic Fever  Pneumon Chickenp HPV: HPW: Measles, Mump	Polio    Other: nia: pox:  pos, Rubella nil.  Result     Normal    Abnormal     Normal    Abnormal     Normal    Abnormal

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

Hospitaliz	ations		Sı	ırgeries				
Year	Reason		Υe	ar Reason				
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			r r					
		7 - 9 N.M 1 M.M. M.		A A A A A A A A A	***			
List any m	nedical problems t	hat other doctors	have diagnose	d				
	-							
			FAMILY HE	ALTH HISTORY				
Please plac	e an "X" in the relev	ant boxes.	the state of the s		THE ALL AL ADDRESS OF THE PARTY OF THE RESIDENCE OF THE PARTY OF THE P			
Condition		Mother	Father	Sibling	Grandparent (maternal)	Grandparent		
Alcoholism			- 100101		:	(paternal)		
Autoimmur	LASTONIANA WARRA, LIN. MORE HAT TAK NOT US OF THE PERSON	CONTRACTION CONTRACTOR	The SX or streams to approximent transfer over	. MARKE LELBON THE THE THE STATE OF THE STATE OF	STANDARD AND AND AND AND AND AND AND AND AND AN	NUMBER OF STREET STREET STREET, SHEET STREET		
Cancer (sp					***************************************			
Diabetes	<i>/</i> - <i>/ F</i> - <i>/</i>		\$	:				
Heart Disea	ase							
High chole:								
Hypertensi		; ;						
Mental Illn	ess	1						
Migraine Multiple Sc	dorocis							
Osteoporos		La la la la composición de la composición della			as on the same	and the second s		
Seizures		3						
Stroke					1			
Thyroid					A A A A A A A A A A A A A A A A A A A	Mar 100 M 101 M 10		
,		LEAL	TU UADITE A	ND PERSONAL SAI	::ETY			
Alcohol	and the second s	per tipe according to a service and a servic			A COLUMN TO THE CONTRACT OF THE COLUMN TO TH	CAMP AND ASSESSED OF SECULIAR		
:	Do you drink alcoh			te type and how many o				
•		l about the amount y	ou drink?	COLUMNIA DE SERVICIO ANTICONAL COMPANIA ANTICONAL SERVICIO ANTICONAL S		]Yes □ No		
:	Have you consider	ed stopping?				lYes □ No		
:	Have you ever exp	erienced blackouts?	THE RESIDENCE OF THE PROPERTY	VANTUUR A MANAGERA PROGRESSION AND A MANAGER MANAGER MANAGER MANAGER MANAGER MANAGER MANAGER MANAGER MANAGER M	. [	]Yes □ No		
,	Are you prone to "	binge" drinking?			<u> </u>	] Yes □ No		
	Do you drive after	drinking?			; [	]Yes □ No		
Caffeine	□ None	☐ Coffee	□ Tea	□ Cola/Soda	The second of the second second of the secon			
	# of cups/cans per	r day?		W		and the second s		
Diet	en Co un un un numera en entre anno un numera en	ecial diet? □ Yes □	No If yes, spe	cify:	de de se til dade i medsed deskriven i til de sever en i skrive hede semit. Des			
	Do you avoid any							
	How much water do you drink per day?  Is it filtered water? □ Yes □ No □ Sometimes							
	,	cal foods you eat for		75				
		cai iouus yuu eat ior	•					
	Breakfast:		dddddddddddddddddddddddddddddddddddddd					
	Lunch:							
,	Dinner:		NAMES OF THE PERSON OF THE PER		AND THE RESIDENCE OF THE PROPERTY OF THE PROPE			
	Snacks:							

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Exercise	☐ Sedentary (No exercise)				AND AND AND AN APPROXIMATION
	☐ 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):	ar-manana la		4	
Tobacco	Do you use tobacco?		Yes		No
	Cigarettes or other form – amt./day: # of years: Or year quit:	per east of east-of (	germen have get a married to a specifyrmin or the	adar i ra era recera	The second second section of the second section of the second second second section sectio
Drugs	Do you currently use recreational or street drugs?	. 🗆	Yes		No
	Have you ever given yourself street drugs with a needle?		Yes		No
Rate your current energy on a scale of 1-10 (10=highest):  Tobacco  Do you use tobacco?	Male		Both		
	Have you been sexually active in the past? ☐ Yes ☐ No Gender of sexual partner(s): ☐Female	. 0	Male		Both
	Are you trying for a pregnancy?		Yes		No
:	If you are not trying for a pregnancy, list contraceptive or barrier method used:	As. vicerrane	Marketon Enteren Tarret	sharra rurusra.	
	Any problems or concern with sexual function or desire?		Yes		No
:				ang attacks as an	and the second second second second second
*			Yes		No
	T		Yes		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		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
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MENTAL HE	FALTH				
Is stress a	major problem for you?		Yes		No
Do you feel	depressed or cry frequently?		Yes		No
Do you par	nic when stressed?		Yes		No
Do you hav	re problems with eating or your appetite?		Yes	, 🗆	No
Have you in	ntentionally harmed yourself?		Yes	: 🗆	No
Have you e	ever seriously thought about hurting yourself?		Yes		No
Have you e	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?				The second second control of the second cont
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rrent? st? (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	Merchanist Communication Commu	Hoarseness	Bruise Easily
	Cardiovascular	er de la companya de	Hypoglycemia	Musculoskeletal
	Ankle swelling	Application of the state of the	Ringing in ear	Back pain (chronic)
	Chest pain	300	Sinus problem	Foot pain
	Elevated blood pressure	And the second s	Sore throat	Gout attack
	Fatigue	obidemic beid o	Eyes	Leg pain
	Irregular heartbeat	Cheve-Obsidance	Blurred Vision	Neck pain
a ded for displaced mentions require	Murmur (heart)		Loss of vision	Neurological
	Palpitations	a control of the cont	Pain or soreness in or about the eyes	Difficulty concentrating
	Shortness of breath at rest	2000	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	т. жонородин	Weight gain	Respiratory
	Dry Skin		Weight loss, unintentional	Asthma
	Excess hair growth	**************************************	Yellowing of skin	Cough
	Extreme thirst	and an arrest of the second	Genitourinary	Wheezing
	Hyperglycemia	The state of the s	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	

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

WOMEN ONLY		
Age at onset of menstruation:		
First day of last menstrual period:/ Number of days of flow:		
Period every days	- Additional acceptance of Additional Complete And Sold Sold Sold Sold Sold Sold Sold Sol	and the same of th
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	· □ Yes	□ No
Do you feel pain or burning with urination?  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?	∵ les	
Do you regularly do testicular self-exams?	□ Yes	□ No
DO YOU regularly UU testicular sen exams:	; L 163	140