

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

PERSONAL INFORMATION			
Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M	<input type="checkbox"/> F	DOB:
Social Security#:			
Street Address			
City	State	Zip	
Home Phone	Cell Phone		
Email Address			
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Previous or referring doctor:		Date of last physical exam:	
Employer		Occupation	
Street Address			
City	State	Zip	
Work Phone	Work Status	Full Time	Part Time
PERSONAL HEALTH HISTORY			
Purpose of Today's Visit:			
What are your top 3 health concerns?			
What are your health goals?			
Previous weight loss programs and successes/failures			
Recent physical exams - physician and date:			
Lab work - physician and date:			
X-Rays, MRI, CT - physician and date:			
Stress Test - physician and date:			
Other Tests – physician and date:			

Childhood illness: Measles Mumps Rubella Chickenpox Rheumatic Fever Polio

Immunizations and dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>

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

List your prescribed drugs and over-the-counter drugs. How long you have been taking them. What are they for and the doctor that prescribed them. Also include any drugs (prescribed and over-the-counter) taken within the last year. Please also list natural medicines/supplements such as vitamins and herbs.

Name of Drug:	Strength:	Frequency:	How Long Taken:	Condition Prescribed For:	What Doctor Prescribed It:

Allergies to medications, such as penicillin, sulfa, etc.

Name the Drug	Reaction You Had

Allergies to foods, such as wheat/gluten, milk, soy, eggs, seafood, etc.	
Name of Food	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise: walk jog weights other_____ (i.e., less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise: walk jog weights other_____ (i.e., 4x/week or more for 30 minutes)		
Diet	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank sugar intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea <input type="checkbox"/> Cola <input type="checkbox"/> Energy/Sports Drinks
	# of cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
Drugs	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex	Are you sexually active?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you trying for a pregnancy?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?		<input type="checkbox"/> Yes <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal Safety	Do you live alone?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have frequent falls?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have vision or hearing loss?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?		<input type="checkbox"/> Yes <input type="checkbox"/> No

	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

(This includes cancer, heart disease, stroke, obesity, diabetes, arthritis, autoimmune diseases)

AGE		SIGNIFICANT HEALTH PROBLEMS	AGE		SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Mother				<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
	<input type="checkbox"/> M			Grandmother	
	<input type="checkbox"/> F			<i>Maternal</i>	
<input type="checkbox"/> M			Grandfather		
<input type="checkbox"/> F			<i>Maternal</i>		
<input type="checkbox"/> M			Grandmother		
<input type="checkbox"/> F			<i>Paternal</i>		
<input type="checkbox"/> M			Grandfather		
<input type="checkbox"/> F			<i>Paternal</i>		

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How often and with what do you feel stressed in a given week: <input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Marriage <input type="checkbox"/> Money <input type="checkbox"/> Work <input type="checkbox"/> Sex		
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times _____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a prostate and rectal exam? Date of prostate exam: _____ Date of rectal exam: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Lungs	<input type="checkbox"/> Nerves
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Immune	<input type="checkbox"/> Muscles
<input type="checkbox"/> Brain	<input type="checkbox"/> Back	<input type="checkbox"/> RECENT CHANGES IN:
<input type="checkbox"/> Ears	<input type="checkbox"/> Gastro Intestinal	<input type="checkbox"/> Weight
<input type="checkbox"/> Eyes	<input type="checkbox"/> Pancreas	<input type="checkbox"/> Energy Level
<input type="checkbox"/> Nose	<input type="checkbox"/> Kidney	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Mouth	<input type="checkbox"/> Male Genito Urinary	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Throat	<input type="checkbox"/> Female Genito Urinary	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Indocrine (Hormones)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Chest/Heart/Vascular	<input type="checkbox"/> Circulation	<input type="checkbox"/> Other: _____

STATEMENT OF ACKNOWLEDGEMENT

Your signature below indicates that you understand that you are solely responsible for any treatment rendered in this office. All services rendered to you are charged directly to you, and you are personally responsible for payment. In most instances, this office does not accept insurance of any kind. There may be exceptions to this policy, but this will be addressed on an individual basis. (Please advise us immediately if you are a Medicare patient, as we do not treat Medicare patients for services covered by Medicare.)

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit. Your signature also indicates that you authorize the staff to perform any necessary services needed during diagnosis and treatment, and that you understand the above information and guarantee this form was completed correctly to the best of your knowledge and understand it is your responsibility to inform this office of any changes to the information you have provided.

Signature: _____ Date: _____

