

HEALTH HISTORY QUESTIONNAIRE

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

TODAY'S DATE: _____

PATIENT INFORMATION

NAME (<i>Last, First, M.I.</i>):		☐ M ☐ F	DOB:
MARITAL STATUS: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
PREVIOUS OR REFERRING DOCTOR:		Date of last physical exam:	
		Preferred Pharmacy:	

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESS: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Other

Immunizations and dates:	☐ Tetanus	☐ MMR
	☐ Pneumonia	☐ COVID-19
	☐ Hepatitis	☐ Other
	☐ Influenza	

LIST ANY MEDICAL PROBLEMS DIAGNOSED BY A PROVIDER

SURGERIES

Year	Reason	Hospital

OTHER HOSPITALIZATIONS

Year	Reason	Hospital



HEALTH HISTORY QUESTIONNAIRE

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

MEDICATIONS

Medication	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS

Medication	Reaction

HEALTH HABITS

Exercise	Sedentary			☐ Yes	☐ No
	Mild exercise			☐ Yes	☐ No
	Occasional vigorous exercise			☐ Yes	☐ No
	Regular vigorous exercise				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	How many drinks per week?				
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes - pks./day:	☐ Chew - #/day:	☐ Pipe - #/day:	☐ Cigars - #/day:	
	# of years:	Or year quit:			
Recreational Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No

HEALTH HISTORY QUESTIONNAIRE

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

PERSONAL SAFETY

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 or Living Will?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

Relatives	Age	Major Health Problems
Father		
Mother		
Sibling(s)		
Children(s)		
Grandparent(s)		

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

HEALTH HISTORY QUESTIONNAIRE

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

WOMEN'S HEALTH (IF APPLICABLE)

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'S HEALTH (IF APPLICABLE)

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? ☐ Yes ☐ No

Any difficulty with erection or ejaculation? ☐ Yes ☐ No

Any testicle pain or swelling? ☐ Yes ☐ No

Date of last prostate and rectal exam? ☐ Yes ☐ No

HEALTH HISTORY QUESTIONNAIRE

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

OTHER PROBLEMS / SYMPTOMS		
☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	
Explain (if any)		

Signature: _____

Date: _____