Name *(Last, First, M.I.)*:_____ ☐ M ☐ F **DOB:**____/____/____

HEALTH HISTORY QUESTIONNAIRE

Please complete this entire questionnaire. It will provide your care team with important information about your health. All answers contained in this questionnaire are strictly confidential and will become part of your medical record.

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

Number of children: _____ **How many live with you?** _____ **Occupation is/was:** _____

Previous or referring doctor:_____ **Date of last physical exam:** _____

HEALTH HISTORY

Tests/Screenings and Dates: ☐ Eye Exam_____ ☐ Colonoscopy_____ ☐ Dexa Scan_____

Hospitalizations /or Surgeries

Year_____ Reason_____ Hospital _____

Year_____ Reason_____ Hospital _____

Year_____ Reason_____ Hospital _____

Year_____ Reason_____ Hospital _____

☐ I have had no surgeries ☐ I have never been hospitalized

Have you ever had a blood transfusion? ☐ Y ☐ N

Please list other physicians you have seen in the last 12 months, and for what reason.

_____

_____

Name (Last, First, M.I.):_____DOB ___/___/_____

FAMILY MEDICAL HISTORY

Please indicate if **YOUR FAMILY** has a history of the following: *(ONLY include parents, grandparents, siblings, and children)*

☐ I am adopted and do not know biological family history ☐ Family History Unknown

☐ Mother, Grandmother, or Sister developed heart disease before the age of 65

☐ Father, Grandfather, or Brother developed heart disease before the age of 55

Disease/Conditions	Relationship to you (mom, grandparents, siblings, and children)
☐ Seizures/Convulsions	_____
☐ Colon Cancer	_____
☐ Migraines	_____
☐ Osteoporosis	_____
☐ Alcohol Abuse	_____
☐ Depression	_____
☐ Lung/Respiratory Disease	_____
☐ Anemia	_____
☐ Diabetes	_____
☐ Breast Cancer	_____
☐ Anesthetic Complication	_____
☐ Heart Disease	_____
☐ Rectal Cancer	_____
☐ Arthritis	_____
☐ Asthma	_____
☐ High Cholesterol	_____
☐ High Blood Pressure	_____
☐ Other Cancer	_____
☐ Bladder Problems	_____
☐ Kidney Disease	_____
☐ Stroke/CVA of the Brain	_____
☐ Bleeding Disease	_____
☐ Leukemia	_____
☐ Thyroid Problems	_____
☐ Severe Allergy	_____

Name (Last, First, M.I.):_____ DOB ___/___/_____

Personal Safety

Do you live alone? ☐ Y ☐ N

Do you have frequent falls? ☐ Y ☐ N

Do you have vision or hearing loss? ☐ Y ☐ N

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? ☐ Y ☐ N

How often do you have sun exposure? ☐ Occasionally ☐ Frequently ☐ Rarely

Have you ever experienced a sunburn? ☐ Y ☐ N

How often do you wear your seatbelt? ☐ Occasionally ☐ Frequently ☐ Always

These questions are for WOMEN ONLY

Age at onset of menstruation: _____ Date of last Menstruation: _____ Period every _____days

Heavy periods, irregularity, spotting, pain, or discharge? ☐ Y ☐ N

Number of pregnancies:_____ Number of live births:_____

Are you pregnant or breastfeeding? ☐ Y ☐ N

Have you had a D&C, hysterectomy, or Cesarean? ☐ Y ☐ N

Any urinary tract, bladder, or kidney infections within the last year? ☐ Y ☐ N

Any blood in your urine? ☐ Y ☐ N

Any problems with control of urination? ☐ Y ☐ N

Any hot flashes or sweating at night? ☐ Y ☐ N

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? ☐ Y ☐ N

Do you perform monthly breast self exams? ☐ Y ☐ N

Experienced any recent breast tenderness, lumps, or nipple discharge? ☐ Y ☐ N

Date of last pap smear or pelvic exam:_____

These questions are for MEN ONLY

Do you usually get up to urinate during the night? ☐ Y ☐ N

Do you feel pain or burning with urination? ☐ Y ☐ N

Any blood in your urine? ☐ Y ☐ N

Do you feel burning discharge from penis? ☐ Y ☐ N

Has the force of your urination decreased? ☐ Y ☐ N

Have you had any kidney, bladder, or prostate infections within the last 12 months? ☐ Y ☐ N