

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



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.): _____ F M **Date of Birth:** _____

Marital status: Single Partnered Married Separated Divorced Widowed

Number of children: _____ **Age Range of Children:** _____

Previous or referring doctor: _____

Reason for visit: _____

PERSONAL HEALTH HISTORY

List all medications and supplements taken regularly

Name the Drug or Supplement	Taken for:	Dose (strength and frequency)	Prescribed by: (write "Self" if self-prescribed)

Do you have any known allergies to medications? Yes No If yes, please fill out chart below.

Name the Drug	Reaction You Had

Childhood illness: Measles Mumps Rubella Chickenpox Rheumatic Fever Polio Other:

Immunizations: (Please indicate dates.)

<input type="checkbox"/> Tetanus:	<input type="checkbox"/> Pneumonia:
<input type="checkbox"/> Hepatitis A:	<input type="checkbox"/> Chickenpox:
<input type="checkbox"/> Hepatitis B:	<input type="checkbox"/> HPV:
<input type="checkbox"/> Influenza:	<input type="checkbox"/> MMR: Measles, Mumps, Rubella

Screening Exams: Please indicate the date of your last exam and whether it was normal.

Exam	Date	Result	Exam	Date	Result
Cholesterol		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Hemoccult/Blood in stool		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Colonoscopy		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Mammogram (women)		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
DEXA/Bone Scan		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	PAP (women)		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Dental		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Physical Exam		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Eye Exam		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Prostate (men)		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Glucose/Blood Sugar		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	TB Screening		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

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Hospitalizations		Surgeries	
Year	Reason	Year	Reason

List any medical problems that other doctors have diagnosed

FAMILY HEALTH HISTORY

Please place an "X" in the relevant boxes.

Condition:	Mother	Father	Sibling	Grandparent (maternal)	Grandparent (paternal)
Alcoholism					
Autoimmune					
Cancer (specify type)					
Diabetes					
Heart Disease					
High cholesterol					
Hypertension					
Mental Illness					
Migraine					
Multiple Sclerosis					
Osteoporosis					
Seizures					
Stroke					
Thyroid					

HEALTH HABITS AND PERSONAL SAFETY

Alcohol Do you drink alcohol? Yes No If yes, indicate type and how many drinks per week:

Are you concerned about the amount you drink? Yes No

Have you considered stopping? Yes No

Have you ever experienced blackouts? Yes No

Are you prone to "binge" drinking? Yes No

Do you drive after drinking? Yes No

Caffeine None Coffee Tea Cola/Soda

of cups/cans per day?

Diet Do you follow a special diet? Yes No If yes, specify:

Do you avoid any foods? Yes No If yes, specify:

How much water do you drink per day? Is it filtered water? Yes No Sometimes

Please list the typical foods you eat for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

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Exercise	<input type="checkbox"/> Sedentary (No exercise)						
	<input type="checkbox"/> Mild exercise (for example, climbing stairs, walking 3 blocks, golf)						
	<input type="checkbox"/> Occasional vigorous exercise (for example, work or recreation, less than 4x/week for 30 min.)						
	<input type="checkbox"/> Regular vigorous exercise (for example, work or recreation 4x/week for 30 minutes or more)						
Sleep	Do you have trouble falling asleep?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	Do you wake during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	If yes, do you have trouble falling back asleep?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	Do you wake feeling rested?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	Average number of hours of sleep:						
	Rate your current energy on a scale of 1-10 (10=highest):						
Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	Cigarettes or other form – amt./day:			# of years:		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 currently sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gender of sexual partner(s):	<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> Both
	Have you been sexually active in the past?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gender of sexual partner(s):	<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> Both
	Are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	If you are not trying for a pregnancy, list contraceptive or barrier method used:						
	Any problems or concern with sexual function or desire?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<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 wear your seat belt?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you wear your helmet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Do you avoid excess UV exposure or wear sunscreen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	Is the battery current in your smoke detector?	<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 an Advanced Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
MENTAL HEALTH							
	Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	Do you feel depressed or cry frequently?	<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				
	Have you intentionally harmed yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	Have you ever seriously thought about hurting others?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	Do you feel you have an adequate support system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	Are you currently seeing a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If so, who?			

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Review of systems: Mark "C" for current problems; For problems in the past, please write the YEAR it occurred.			
Current? Past? (Write Date)	Allergic/Immunologic	Current? Past? (Write Date)	Ears, Nose, Mouth, Throat (cont.)
Current? Past? (Write Date)	Hematological	Current? Past? (Write Date)	Musculoskeletal
	Arthritic flare-up		Epistaxis (nosebleeds)
	Hay fever symptoms		Hoarseness
	Cardiovascular		Hypoglycemia
	Ankle swelling		ringing in ear
	Chest pain		Sinus problem
	Elevated blood pressure		Sore throat
	Fatigue		Eyes
	Irregular heartbeat		Blurred Vision
	Murmur (heart)		Loss of vision
	Palpitations		Pain or soreness in or about the eyes
	Shortness of breath at rest		Gastrointestinal
	Shortness of breath in the night		Abdominal pain
	Shortness of breath with exercise		Blood in stool
	Syncope (fainting)		Constipation
	Varicose veins		Diarrhea
	Dermatologic (Skin)		Heartburn
	Eczema		Hemorrhoids
	Hives		Loss of appetite
	Pruritis (itching)		Melena (dark, tarry stools)
	Psoriatic flare-up		Nausea
	Rash		Swallowing difficulty
	Endocrine		Vomiting
	Cold intolerance		Weight gain
	Dry Skin		Weight loss, unintentional
	Excess hair growth		Yellowing of skin
	Extreme thirst		Genitourinary
	Hyperglycemia		Discharge (from urethra)
	Thyroid disease		Painful urination
	Unusual fatigue		Urinary difficulty
	Ears, Nose, Mouth, Throat		Urinary incontinence
	Cough, chronic		Urinary output low
	Difficulty with hearing		Urinating frequently at night
	Ear infection		
			Other? Please explain:

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WOMEN ONLY

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?

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?

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