HEALTH HISTORY QUESTIONNAIRE

For Doctor's Use

GENERAL INFORMATION

Name: Date:

Age: Occupation:

Education: (grade completed) Special interests or hobbies:

How did you hear about our practice?

OTHER MEMBERS OF HOUSEHOLD

	Name	Age	Relationship	Major Medical Problems
1.				
2.				
3.				
4.				
5.				

FAMILY HEALTH HISTORY

List any blood related family member (parent, grandparent, aunt, uncle, sibling, child) who has had any of the following:

Allergy, Asthma, Eczema _____ High Blood Pressure _____

Migraine _____ High Cholesterol _____

Blood Clotting/Bleeding Problem _____ Stroke _____

Ulcer _____ Alcohol/Drug Abuse _____

Glaucoma _____ Depression/Suicide _____

Diabetes _____ Psychiatric Problem _____

Colon Polyp _____ Birth Defect/Genetic Disease _____

Cancer: (include location and age at diagnosis) _____

Heart Disease/Attack: (include type and age at diagnosis) _____

YOUR MEDICAL HISTORY

HOSPITALIZATIONS, OPERATIONS, AND INJURIES List cause or type. Exclude normal pregnancies. YEAR

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

RECURRENT, SERIOUS, OR CHRONIC ILLNESS, current or past, requiring long term medications or repeated doctor visits

1. _____
2. _____
3. _____
4. _____

HAVE YOU EVER HAD?

___ Asthma	___ Liver disease, hepatitis, jaundice	___ Blood transfusion
___ Anemia	___ Gallbladder problems	___ Back trouble
___ High blood pressure	___ High cholesterol or triglycerides	___ Migraine headaches
___ Heart disease/attack	___ Pneumonia	___ Drug or alcohol problems
___ Rheumatic fever	___ Kidney stones	___ Depression
___ Mitral Valve Prolapse	___ Eating disorder/bulimia/anorexia	___ Nervous breakdown/mental illness
___ Heart murmur	___ Tubal or pelvic infections	___ Suicide attempt
___ Thyroid problems	___ Seizures	___ Been in counseling or therapy
___ Ulcer	___ Abnormal PAP smear	___ Precancerous skin lesions

MEDICATION: List any medications that you use at least once a month. This includes prescription medicines, birth control pills, and non-prescription medicines such as pain relievers, vitamins, antacids, laxatives, sinus medication, etc.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES: List any allergies or bad reactions to medications. List medication and type of reaction.

For Doctor's Use

_____

_____

_____

REPRODUCTIVE HISTORY Women only

Age periods began _____

Past methods of birth control _____ _____

Exposure to DES? ___ yes ___ no

Problems with pregnancies? _____

Treatment for infertility? ___ yes ___ no

Number of Pregnancies _____

miscarriages _____

abortions _____

Caesarean sections _____

Living children _____

HISTORY OF ABUSE

Have you ever experiences any physical, emotional, or sexual abuse that you are aware of? ___ yes ___ no

If yes, ___ past ___ current

Was/is the perpetrator a ___ relationship partner ___ family member ___ acquaintance ___ stranger

SEXUAL HISTORY These questions are personal, but very important in providing you with good health care.

How many sexual partners of the opposite sex have you had in your lifetime? None 1-2 3-5 5-10 10-20 20+

How many sexual partners of the same sex have you had in your lifetime? None 1-2 3-5 5-10 10-20 20+

Have you ever had a sexually transmitted or venereal disease? (gonorrhea, chlamydia, genital warts, herpes) ___ yes ___ no

Have any of your sexual partners been bisexual, IV drug users, or had many previous sexual partners? ___ yes ___ no

Have you ever been tested for the AIDS virus? ___ yes ___ no Would you like to be tested today? ___ yes ___ no

HABITS

Smoking: Do you smoke now? ___ yes ___ no

If yes, how many packs per day? _____ Would you like to quit? ___ yes ___ no

If no, did you smoke in the past? ___ yes ___ no

If yes, when did you quit? _____ How many packs per day for how long? _____

Alcohol: Number of drinks per week, including beer and wine _____

Any illicit drug use? (Marijuana, Cocaine) ___ yes ___ no

Any use of intravenous drugs now or in the past? ___ yes ___ no

HEALTH MAINTENANCE HISTORY

When was your last: Complete physical exam? _____ Tetanus shot? _____ EKG? _____

(Women only) Pap Smear? _____ Breast Check? _____ Mammogram? _____

WORK/EXPOSURE HISTORY

Are you working outside of the home currently? ___ yes ___ no

Starting with you most recent job, what type of work have you done?

	Type of work	From	To
1.			
2.			
3.			

Check the items below that you have been exposed to in your work:

___ Fumes and dust
___ Lead, mercury, metal salts
___ Radiation
___ Solvents, degreasers
___ Salicylates, halothanes
___ Coal, asbestos
___ Pesticides/Herbicides
___ Repetitive movements
___ Loud noises
___ Heavy lifting, physical strain
___ Undue stress, pressure
___ Extreme heat or cold
Other _____

OTHER HEALTH CARE PROVIDERS Who else have you seen for your health care in the past five years?

Year	Name of health care provider	Location: City, State	Primary problems cared for