

**Health History Questionnaire**

**PLEASE READ THIS FIRST:**

Please take the time to **completely** fill in all questions. We use an electronic health record system in the clinic and it requires us to enter specific and complete information. We need your help to make this process as easy and efficient as possible. If you have any questions, please ask for help.

Name: <i>(Last, First)</i>	Today's Date: _____/_____/_____
-------------------------------	---------------------------------

**REASON FOR VISIT**

List, in order of importance, your health care goals:

1.
2.
3.

**PERSONAL HEALTH HISTORY**

**Surgeries & Hospitalizations** \*Women - be sure to include childbirth (natural & c-section)

Year	Reason	Hospitalized? <small>(Please write "YES" or "NO")</small>

**Allergies** – Check "yes" or "no" below and then list all allergies separately

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Allergies to medications
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Allergies to food
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Allergies to environment

Name the Medication or Item Allergic to <small>(Be as specific as possible)</small>	Month and Year started	Reaction You Had & Where <small>(example: rash, stomach ache, anaphylaxis, etc)</small>	Severity
	/		<input type="checkbox"/> very mild <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe
	/		<input type="checkbox"/> very mild <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe
	/		<input type="checkbox"/> very mild <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe
	/		<input type="checkbox"/> very mild <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe
	/		<input type="checkbox"/> very mild <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe
	/		<input type="checkbox"/> very mild <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe
	/		<input type="checkbox"/> very mild <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe

**Please indicate if you have or have ever had any of the following health issues and fill out ALL of the information requested. Please indicate the month and year of diagnosis to the best of your ability.**

		Check here if you were formally diagnosed by a doctor	Month and Year you were diagnosed or problems started	Indicate if had condition in <u>Past Only</u>
<input type="checkbox"/>	Anemia – What type:	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	Arthritis – What type: <input type="checkbox"/> osteoarthritis <input type="checkbox"/> psoriatic <input type="checkbox"/> rheumatoid <input type="checkbox"/> other: Which joints:	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	Bipolar disorder	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	Cancer – What type & where:	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	Depression	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	Diabetes – what type: <input type="checkbox"/> insulin dependent <input type="checkbox"/> non-insulin dependent	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	Digestive/ GI issues: <input type="checkbox"/> bloating <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> gas <input type="checkbox"/> heartburn <input type="checkbox"/> reflux Describe:	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	Epilepsy/ Seizures – what type:	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	Gallbladder issues – describe:	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	Glaucoma – What type: <input type="checkbox"/> open <input type="checkbox"/> closed	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	Gout – how often are attacks:	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	Headaches – What type & how often: Are your headaches migraines? <input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	Heart issues – What type: <input type="checkbox"/> murmur <input type="checkbox"/> valve issues <input type="checkbox"/> pacemaker <input type="checkbox"/> congestive heart failure Explain:	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	Kidney stones – What type: How often:	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	Leber’s optic neuropathy (hereditary eye disease)	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	Polycystic ovarian syndrome (PCOS)	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	Prostate issues – please explain:	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	Sleep apnea	<input type="checkbox"/>	/	<input type="checkbox"/>
<input type="checkbox"/>	Thyroid – What type: <input type="checkbox"/> hypo (underactive) <input type="checkbox"/> hyper (overactive)	<input type="checkbox"/>	/	<input type="checkbox"/>

**Other:**

**WOMEN ONLY**

Date of last menstruation: \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you pregnant or breastfeeding?  Yes  No

**List ALL Prescribed Drugs** (Inhalers, Contraceptives, etc.) and **Over-the-Counter Drugs** and **Nutritional Supplements** (Allergy medications, Aspirin, Vitamins, Herbs, etc.) you are currently taking in the following table:

Drug/ Nutritional Supplement (Please also list manufacturer of supplements if known)	Strength/ Dosage	Frequency Taken	Date Started (month/year)	Are you taking as prescribed?
			/	<input type="checkbox"/> Yes <input type="checkbox"/> No
			/	<input type="checkbox"/> Yes <input type="checkbox"/> No
			/	<input type="checkbox"/> Yes <input type="checkbox"/> No
			/	<input type="checkbox"/> Yes <input type="checkbox"/> No
			/	<input type="checkbox"/> Yes <input type="checkbox"/> No
			/	<input type="checkbox"/> Yes <input type="checkbox"/> No
			/	<input type="checkbox"/> Yes <input type="checkbox"/> No
			/	<input type="checkbox"/> Yes <input type="checkbox"/> No
			/	<input type="checkbox"/> Yes <input type="checkbox"/> No

**FAMILY HEALTH HISTORY**

When answering this section, please list **ALL** family members' health problems or write in **"healthy"**. Here are some examples: AIDS, alcoholism, allergies, arthritis, asthma, cancer (list the type), depression, diabetes (list the type), drug abuse, heart attack, heart disease, high blood pressure (HTN), migraines, lung disease, obesity, seizures, stroke, suicide, or tuberculosis.

	Age Now	Age at Death	Significant Health Problems or Cause of Death		Age Now	Age at Death	Significant Health Problems or Cause of Death
Father				Children	<input type="checkbox"/> M <input type="checkbox"/> F		
Mother					<input type="checkbox"/> M <input type="checkbox"/> F		
Brothers and Sisters	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandparents (Mother's Side)			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Male</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Female</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandparents (Father's Side)			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Male</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Female</i>			

**LIFESTYLE ISSUES**

Alcohol: Do you drink alcohol?  Yes  No (1 "drink" = 12 oz beer or 1.5 liquor or 5 oz wine)  
If yes, what kind? \_\_\_\_\_ How many drinks per week? \_\_\_\_\_

Tobacco products?  Current use, # of years: \_\_\_\_\_  Past use, year quit: \_\_\_\_\_  Never used  
 Cigarettes - Pks/day \_\_\_\_\_  Chew - #/day \_\_\_\_\_  Pipe - #/day \_\_\_\_\_  Cigars - #/day \_\_\_\_\_

Drugs: Do you currently or have you ever used recreational or street drugs?  Yes  No  
If yes, please explain: