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HEALTH HISTORY QUESTIONNAIRE

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

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

Previous or Referring Doctor: **Date of Last Physical Exam:**

PERSONAL HEALTH HISTORY

Immunizations and Dates:

☐ Tetanus ☐ Pneumovac 23
☐ Hepatitis ☐ Prevnar 13
☐ Influenza ☐ Shingrix

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries & Hospitalizations:

Year	Reason	Doctor/Hospital

Colonoscopy: Date:	**Results:**	**Name of GI Specialist:**
Cardiac Studies:	**Results:**	**Name of Cardiac Specialist:**
Mammogram Date:	**Results:**	
DEXA/Bone Density Date:	**Results:**	

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Name of Drug	Strength	Frequency Taken

Allergies to Medications:

Name of Drugs	Reactions You Had

HEALTH HABITS AND PERSONAL SAFETY

Occupation/Job:

Exercise:
☐ Sedentary (No exercise)
☐ Mild Exercise (1-2 times/week)
☐ Regular Vigorous Exercise (4-5 x/week for 30 minutes or more)

Diet:
Are you dieting? ☐ Yes ☐ No
Rank Salt Intake: ☐Hi ☐Med ☐Low
Rank Fat Intake: ☐Hi ☐Med ☐Low

Caffeine: ☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day?

Alcohol:	Do you drink alcohol? ……...☐ Yes ☐ No If yes, what kind? _____ #Drinks/night _____#Drinks/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
Tobacco:	Do you use tobacco? ……...☐ Yes ☐ No Do you Vape? ……...☐ Yes ☐ No ☐ Cigarettes - Pks/day_____☐ Chew - #cans/day_____ ☐ Cigars - #/day _____ ☐ # of Years Used _____☐ or Year Quit_____
Drugs:	Do you currently use recreational or street drugs? ☐ Yes ☐ No Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No

Sex:	Are you sexually active? ☐ Yes ☐ No Sexual Preference ☐ M ☐ F
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 and/or Living Will? .....☐ Yes ☐ No Would you like information on the preparation of these? .....☐ Yes ☐ No Physical and/or mental abuses 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? ☐ Yes ☐ No

FAMILY HEALTH HISTORY

	Age	Age at Death	Significant Health Problems or Cause of Death		Age	Age at Death	Significant Health Problems or Cause of Death
Father				**Children**	☐ **M** ☐ **F**		
Mother					☐ **M** ☐ **F**		
	☐ **M** ☐ **F**				☐ **M** ☐ **F**		
Siblings	☐ **M** ☐ **F**				☐ **M** ☐ **F**		

MENTAL HEALTH

Is stress a major problem for you? ..... ☐ Yes ☐ No
Do you feel depressed? ..... ☐ Yes ☐ No
Do you feel anxious or suffer from panic attacks? ..... ☐ Yes ☐ No
Do you have problems with eating or your appetite? ..... ☐ Yes ☐ No
Do you cry frequently? ..... ☐ Yes ☐ No
Have you ever attempted suicide or thought about hurting yourself? ..... ☐ Yes ☐ No
Do you have trouble sleeping? ..... ☐ Yes ☐ No
Have you ever seen a counselor? ..... ☐ Yes ☐ No