

Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: <i>(Last, First, M.I.)</i>	<input type="checkbox"/> Male	Date of Birth:
	<input type="checkbox"/> Female	

Address:	Phone:
	Email:

Marital Status: Single Partnered Married Separated Divorced Widowed

Previous or Referring Doctor:	Date of Last Physical Exam:
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REASON(S) FOR COMING TO THE DOCTOR

Please list and explain:

PERSONAL HEALTH HISTORY

Childhood Illness: Measles Mumps Rubella Chicken Pox Rheumatic Fever
 Polio

Immunizations and Dates: Tetanus Pneumonia
 Hepatitis _____ Chicken Pox _____
 Influenza _____ MMR

Blood type: A B AB O + / - (circle) *(Measles, Mumps, Rubella)*

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries:

Year	Reason	Hospital
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Other Hospitalizations:

Year	Reason	Hospital
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Have you ever had a blood transfusion? Yes No

List any Prescription Drugs and Over-the-Counter Medications You are Using (including vitamins, supplements, inhalers, oral contraceptives):

Name of Drug	Strength	Frequency Taken

Allergies to Medications:

Name of Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Exercise: Sedentary (No exercise) Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
 Occasional Vigorous Exercise (i.e., work or recreation less than 4x/week for 30 min.)
 Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet: Are you dieting?..... Yes No
 If yes, are you on a physician prescribed medical diet? Yes No
 Number of meals you eat in an average day? _____
 Rank Salt Intake: Hi Med Low Rank Fat Intake: Hi Med Low

Caffeine: None Coffee Tea Cola Amount Per Day? _____

Alcohol: Do you drink alcohol? Yes No
 If yes, what kind? _____ How many drinks per week? _____
 Are you concerned about the amount you drink? Yes No

Tobacco: Do you use tobacco? Yes No
 Cigarettes - Packs/day _____ Chew - Amount/day _____
 Pipe - #/day _____ Cigars - #/day _____
 # of Years _____ Quit, Year _____

MENTAL HEALTH

Is stress a major problem for you? Yes No
 Do you feel depressed? Yes No
 Do you panic when stressed? Yes No
 Do you have problems with eating or your appetite? Yes No
 Do you cry frequently? Yes No
 Have you ever attempted suicide? Yes No
 Have you ever seriously thought about hurting yourself? Yes No
 Do you have trouble sleeping? Yes No
 Have you ever been to a counselor? Yes No

WOMEN ONLY

Age at onset of menstruation: _____. Date of last menstruation: _____.

Period every _____ days. Heavy periods, irregularity, spotting, pain, or discharge? Yes No

Number of pregnancies _____. Number of live births _____.

Are you pregnant or breastfeeding? Yes No

Have you had a D&C, hysterectomy, or Cesarean section? 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

Date of last pap smear and rectal exam? _____.

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

Date of last prostate and rectal exam? _____.

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin _____ <input type="checkbox"/> Head/Neck _____ <input type="checkbox"/> Ears _____ <input type="checkbox"/> Nose _____ <input type="checkbox"/> Throat _____ <input type="checkbox"/> Lungs _____ <input type="checkbox"/> Chest/Heart _____	<input type="checkbox"/> Back _____ <input type="checkbox"/> Bladder _____ <input type="checkbox"/> Bowels _____ <input type="checkbox"/> Circulation _____ Recent Changes In: <input type="checkbox"/> Weight _____ <input type="checkbox"/> Energy Level _____	<input type="checkbox"/> Ability to Sleep _____ Other Pain/Discomfort: _____
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HEALTH GOALS

What are your specific health goals now and for the future?

COMMITMENT LEVEL

On a scale from 1-10 (10 being the highest) what is your level of commitment to your health?

What are you willing to do to improve your health?

How long do you think it will take to reach your health goals?

What do you think it will take to achieve wellness?