

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

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

Name (Last)	(First)	(Middle)	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Unspecified	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed						
Previous or referring doctor:				Date of last physical exam:		

PERSONAL HEALTH HISTORY

Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio		
Immunizations and dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR Measles, Mumps, Rubella

List any medical problems that other doctors have diagnosed

Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

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Exercise	<input type="checkbox"/> Sedentary (No exercise)								
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)								
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)								
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)								
Diet	Are you dieting?							<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?							<input type="checkbox"/> Yes	<input type="checkbox"/> No
	How often do you eat breakfast?			<input type="checkbox"/> Always	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> Seldom or never		
	When you eat breakfast, how often is it healthy?			<input type="checkbox"/> Always	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> Seldom or never		
	How many servings of the following do you consume daily?								
	Fruit	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7+
	Vegetables	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7+
	Whole Grains	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7+
	Dairy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7+
	Sweets	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7+
Saturated Fats	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7+	
Water	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6-7	<input type="checkbox"/> 8+	
How many servings of the following do you eat weekly?									
Red meat	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3-4	<input type="checkbox"/> 5-6	<input type="checkbox"/> 7-9	<input type="checkbox"/> 10-13	<input type="checkbox"/> 14+	
Poultry	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7+	
Fish	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7+	
Plant-based proteins	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7+	
Leafy Green Vegetables	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7+	
Nuts and seeds	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7+	
Sweetened beverages	<input type="checkbox"/> 0	<input type="checkbox"/> 1-3	<input type="checkbox"/> 4-6	<input type="checkbox"/> 7-13	<input type="checkbox"/> 14+				

	You need excellent nutrition for excellent health. Are you ready to strive for excellent nutrition?						
	<input type="checkbox"/> Not interested	<input type="checkbox"/> Yes, but not right now	<input type="checkbox"/> Yes, I'm ready	<input type="checkbox"/> Recently improved my nutrition	<input type="checkbox"/> Have worked on good nutrition for more than 6 months		
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med		<input type="checkbox"/> Low		
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med		<input type="checkbox"/> Low		
Sleep	How many hours of sleep do you get at night?	<input type="checkbox"/> <5	<input type="checkbox"/> 5-6	<input type="checkbox"/> 7-8	<input type="checkbox"/> 9+		
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea		<input type="checkbox"/> Cola		
	# of cups/cans per day?						
Alcohol	Do you drink alcohol?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?						
	How many drinks per week?						
	Are you concerned about the amount you drink?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you considered stopping?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever experienced blackouts?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you prone to "binge" drinking?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you drive after drinking?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco	Do you use tobacco?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day		<input type="checkbox"/> Chew - #/day		<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day	
	<input type="checkbox"/> # of years		<input type="checkbox"/> 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
Occupational	I enjoy my work.	<input type="checkbox"/> Always	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> Seldom or never		
	I am satisfied with the balance between my work and leisure time.	<input type="checkbox"/> Always	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> Seldom or never		
	I am satisfied with my ability to manage and control my work load.	<input type="checkbox"/> Always	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> Seldom or never		
	The level of stress in my work environment is manageable for me.	<input type="checkbox"/> Always	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> Seldom or never		
	At work, my level of authority is consistent with my level of responsibility.	<input type="checkbox"/> Always	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> Seldom or never		
Values, Spirituality, and Beliefs	I feel that my life has purpose.	<input type="checkbox"/> Always	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> Seldom or never		
	I am able to discuss my values and beliefs with my family and friends in a reasonable manner.	<input type="checkbox"/> Always	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> Seldom or never		
	My actions are guided by my own beliefs rather than the beliefs of others.	<input type="checkbox"/> Always	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> Seldom or never		
	I spend a portion of every day in personal reflection.	<input type="checkbox"/> Always	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> Seldom or never		
	I am tolerant of the values and beliefs of others.	<input type="checkbox"/> Always	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> Seldom or never		

Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous 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 have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<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			Grandmother Maternal	
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandfather Maternal	
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandmother Paternal	
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandfather Paternal	

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<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
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times _____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

Patient Signature _____ Date _____