Health History Questionnaire

Name:_____	**Date of Birth**: _____ **Sex at birth: Male Female Decline to answer**

Personal history	Have you been diagnosed with any of the following? Please circle the appropriate one (s).

Allergies	Chicken Pox	Eczema	Hepatitis/ Liver Disease	Kidney Disease	Other Mental Illness _____	Shingles
Anemia	COPD	Epilepsy	Herpes	Kidney Stones	Osteoporosis	Strokes
Anxiety	Depression	Fibromyalgia	High Cholesterol	Lung Disease (other than COPD)	Psoriasis	Thyroid Disease
Arthritis	Diabetes Type _____	Frequent Urine infections	High Blood Pressure	Lupus	Rheumatoid Arthritis	Tuberculosis
Asthma	Diverticulosis	Gout	HIV	Measles	Rheumatic Fever	Ulcers
Cancer Type_____	Drug/ Alcohol Dependence	Heart Disease	Irritable Bowel	Migraines	Seizures	Venereal Disease
OTHER:						

Surgeries / Hospital Admissions (non-pregnancy)	Illness or Operation and YEAR	Illness or Operation and YEAR

List all medications/ vitamins/ supplements you are now taking detailing the dosage and the frequency. <u>Include those you buy without a prescription.</u> (Write on the back if you need additional space.)

Medication/ Vitamin/ Supplement:

Vaccine history- Year of last inoculation (if unknown, put ?)	**Test/ Exam**- Year of most recent exam

Tetanus/ TD/ TDAP	TB test
Influenza/ Flu	Flex Sig
Pneumonia	Colonoscopy
Shingles	
OTHER:	

Allergies (if none, write none):	

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Name: _____ **DOB:_____**

Symptoms	Please circle the symptom(s) below if you have experienced them regularly over the last 5 years.

Decreased hearing	Hayfever / Allergies	Leg Pain: when walking or doing nothing?	Urinary loss of control	Persistent nausea/vomiting
Double or blurred vision	Headaches- frequent	Bruise easily	Loss of appetite-recent	Moodiness
Failing vision	Shortness of breath: On exertion or lying flat?	Numbness/ tingling sensations	Abdominal pain-chronic	Suicidal Thoughts
Eye Pain	Wheezing	Tremor/hands shaking	Heartburn	Feeling of worthlessness
Nose bleeding-recurrent	Chronic cough	Back pain -recurrent	Constipation	Sleeping difficulty
Sinus trouble	Chest pain	Urine infections-frequent	Diarrhea	Night sweats
Sore throat-frequent	Heart Murmur	Blood in urine	Bloody or tarry stools	Memory Loss Phobia
Hoarseness-prolonged	Irregular Heartbeat/ Palpitations	Pain during urination	Hemorrhoids	Nervousness Agitation
Rashes Hives	Varicose veins/ Phlebitis	Nighttime urination more than twice	Gall bladder trouble	Hot flashes

Social History	

Caffeine/ Coffee/ Tea intake	NONE Approximate amount of cups per day _____
Alcohol intake	NONE Approximate oz per week _____ If not weekly, approximate oz per month _____
Marijuana use	NONE/ NEVER Past- Present-
Illicit Drugs	NONE/ NEVER Past- Present
Smoking status	NONE/ NEVER Approximate packs per day_____ Age you started smoking _____ Year or Age quit _____
Occupation Sexual Orientation	 -Heterosexual -Homosexual -Bisexual -Unsure -Decline to answer -OTHER:

GYN History	**FEMALE SEX ONLY (MALE SEX, SKIP TO BOTTOM)** - Circle appropriate and input information on right column

Health History Questionnaire

Name: _____ DOB:_____

Menstrual flow

-Regular (every 21-40 days) - Irregular (< 21 or > 40 days) -Pain -Cramps

Days of flow _____

First day of last menstrual period _____ Age of first period _____ If post menopausal, age at menopause _____

Pain/ bleeding during or after sexual intercourse?

-Yes -No

Number of:

-Pregnancies _____ -Live births _____ -Miscarriages _____ -Abortions _____

Method of birth control

-NONE -Medication (please add name, dose and frequency to medication list: Injection, Hormone pills, Implant) -IUD -Tubal ligation

-Partner Vasectomy -Rhythm Condom Barrier (condom/ diaphragm)

Year of most recent:

-Pap _____ Normal/ Abnormal

-Mammogram _____ Normal/ Abnormal

Vaginal discharge

-Yes -No

Family History	If any blood relative has suffered any of the following please circle and indicate which relative by putting the # and relation in the blank column.

1. Alcoholism	2. Cancer type_____	3. Hay Fever	4. High blood pressure	5. Osteoporosis	6. Drug abuse
7. Asthma	8. Diabetes	9. Heart Disease	10. Mental Illness	11. Stroke	12. Glaucoma
13. Lupus	14. Rheumatoid Arthritis	15. High Cholesterol	16. Migraine	17. Thyroid Disease	18. Other: _____