HEALTH HISTORY QUESTIONAIRRE

Full Name:	
Name You Prefer to be Called	
Address:	
Cell Phone Number:	
Home Phone Number:	
Birthday:	
Ethnicity:	
Languages:	
Primary Insurance:	
Primary Insurance ID & Group Number, Effective Date:	
Secondary Insurance:	
Secondary Insurance ID & Group Number, Effective Date:	
Preferred Email:	
Emergency Contact Name:	
Emergency Contact Phone Number:	
Preferred Local Hospital System:	
Pharmacy Name:	
Pharmacy Phone Number:	
Pharmacy Fax Number:	
Usual Height:	
Usual Weight:	

ALLERGIES: Please list any allergies you have to medications, and what reaction occurs. Also list any allergies to food or things in the environment.

Allergen	Reaction	Age of Onset

MEDICATIONS: Please list any medications, prescription or over the counter, and any health supplements you are taking. List the name, dose (miligrams, micrograms, units etc) and how many times per day you take it, nad the indication or reason you take it.

Medicine	Dosage	Times Per Day	Indication

PAST MEDICATIONS: Are there any medications you have taken in the past? Why were they stopped?

Medicine	Reason Discontinued

INTRODUCTION:

How did you learn about our office? What are your goals for your first visit?

How would you describe your health?

What are your health goals?

What are your bigger life goals, things that you would like to do in the next 10 years?

HISTORY OF PRESENT ILLNESS:

What is currently your most concerning health problem?

What measures have you taken so far to address it (treatments, medications, specialists seen).

PAST MEDICAL HISTORY: Please list your medical problems, and approximate date it began. This is different than a symptom. For example a symptom might be difficulty hearing. A diagnosis would be sensorineural hearing loss. A symptom might be headache. A diagnosis would be migraine.

Diagnosis	Date Onset	Treatments	Status
			Stable
			Stable
			Stable
			Stable
			Stable
			Stable
			Stable
			Stable
			Stable
			Stable
			Stable
			Stable
			Stable
			Stable
			Stable
			Stable
			Stable
			Stable
			Stable
			Stable
			Stable

REVIEW OF SYSTEMS: Please list any symptoms that bother you, from head to toe.

GENERAL (Weight, sleep energy level etc):	
SKIN:	
HEAD, NECK:	
EARS, EYES, THROAT:	
LUNGS & BREATHING:	
HEART & CIRCULATION:	
GASTROINTESTINAL:	
GENITAL & URINARY:	
GYNECOLOGIC & REPRODUCTIVE:	
MUSCULOSKELETAL:	
NEUROLOGIC:	
PSYCHIATRIC:	
FEET:	
OTHER	

PAST SURGICAL HISTORY: Please list surgeries you have had, their approximate date/hospital and the surgeon.

Surgery	Date & Location	Surgeon	Indication

HOSPITALIZATIONS: Please list any times other than surgery you have stayed overnight in the hospital, the date, reason and which hospital.

Year	Hospital/ Location	Reason

CARE PROVIDERS: Please list any professionals involved in your care. This may include internists, dentists, eye doctors, massage therapists, chiropracters, specialists etc. ****Please Include a phone number **and fax** number.

Name	Specialty	Phone	Fax

FAMILY HISTORY: Please note your family member and any health conditions they have had.

Relationship	Health Conditions
Mother	
Father	
Others:	

BIRTH & CHILDHOOD HISTORY: Describe what you know about your own birth.

Do/Did you know your birth parents?	Yes ◯	No ◯
In known, was your own birth vaginal or surgical delivery?	Vag ◯	Surg ◯
Did your mom have any health conditions or exposures during pregnancy/delivery?	Yes ◯	No/Unknown ◯
How would you describe your childhood?		

EXPOSURE HISTORY:		
Have you ever been exposed to chemicals, irritants or pollutants in the past?	Yes ◯	No ◯
Have you ever had concerning animal, insect or tick bites?	Yes ◯	No ◯

SEXUAL & GENDER HEALTH:			
What was your gender at birth?			
What is your current gender identity?			
Have you undergone any medical treatment to transition gender?	Yes ◯	No ◯	
Do you have any question or concern about your gender identity?	Yes ◯	No ◯	
In your intimate relationships, do you favor partners who are male, female or both?	M ◯	F ◯	B ◯
Do you have any questions about your sexual health?	Yes ◯	No ◯	
Have you had any sexually transmitted diseases? If so, which?			

REPRODUCTIVE HEALTH HISTORY:		
Are you currently sexually active?	Yes ◯	No ◯
Do you have living or deceased children?	Yes ◯	No ◯
Have you had challenges with fertility?	Yes ◯	No ◯
IF YOU HAVE A UTERUS:		
Have you ever been pregnant?	Yes ◯	No ◯
If yes, how many pregnancies have you had?		
Have you experienced abortions, spontaneous or elective?	Yes ◯	No ◯
At what age did you begin periods?		
If menopausal, what age did periods cease?		
If you have periods, how often do they occur?		
If you have periods, how many days do they usually last?		
Do you take any steps to prevent pregnancy? Which?		

PSYCHIATRIC HISTORY:		
What areas of your life are most stressful for you, if any?		
What sorts of things do you do to relieve stress?		
Do you feel depressed or anxious more than most people?	Yes ◯	No ◯
Have you ever been formally diagnosed with a mental health condition?	Yes ◯	No ◯
Have you ever had to stay overnight in the hospital for mental health reasons?	Yes ◯	No ◯
Have you been under the care of a psychiatrist in the past?	Yes ◯	No ◯

SPIRITUAL HISTORY:	
Is spiritual faith important to you?	
Is there a particular religious faith or teaching in which you participate? If so which?	

SOCIAL HISTORY:

Birth Place	
Other Places Lived	
Relationship Status	
Number of Offspring	
Last grade completed	
Past Jobs	
Current Job	
Hobbies	
Exercise Habits	
Cigarettes (Packs Per Day)	
Other tobacco	
Cannibis use	
If ex-smoker, # years smoked	
If ex-smoker, year quit	
Alcohol Use (Drinks per day)	
Caffeine Use	
Other Recreational Drugs	
If sober, year since last use	

ADVANCE DIRECTIVES:

Who you would want called in the event of an emergency?		
Who you would want to make decisions for you if you are unconscious?		
Do you have an advance directive or living will?	Yes ◯	No ◯
Do you have an advance directive that states "Do Not Resuscitate" (DNR)?	Yes ◯	No ◯

PERMISSIONS:

Please list the name and phone number of any other individuals who you wish to be allowed access to your health information. Indicate their relationship to you. Please note if there is a clergy person or spiritual leader who you would want notified in the event of a serious illness.

Name	Relationship	Phone

HEALTH MAINTENANCE: Please not if you have or have not had the following tests, and the approximate date:

Task	When last completed	Location	Any abnormality?
Eye exam			
Dental exam			
Hearing exam			
EKG			
Stress test			
Echocardiogram			
Colonoscopy			
Flu vaccine			
Pneumonia vaccine			
Tetanus vaccine			
Shingles vaccine			
Mammogram for females			
Pap Smear for females			
PSA for males			
Bone density test			
Sleep Study			
Pulmonary Function Test			
Chest X-ray			
TB test (PPD)			

SAFETY CONCERNS:

	YES	NO	N/A
Do you always wear a bike helmet?	◯	◯	◯
Do you think you are at risk of HIV or sexually transmitted disease?	◯	◯	
Do you keep firearms in your home?	◯	◯	
If so, are they stored in a locked place?	◯	◯	
Do you have working smoke detectors?	◯	◯	
Do you have a working carbon monoxide detector?	◯	◯	
Do you feel safe in your neighborhood?	◯	◯	
Is there anyone in your life now who says abusive things or has physically harmed you?	◯	◯	
Is there anyone in your past who said abusive things to you or physically harmed you?	◯	◯	
Is there any one using your money without your permission?	◯	◯	
Do you have problems with walking or falls?	◯	◯	
Do you or anyone in your life have concerns about your driving safely?	◯	◯	◯
Have you ever felt you needed to cut down on alcohol drinking?	◯	◯	
Have people annoyed you by criticizing your drinking?	◯	◯	
Have you ever felt guilty about drinking?	◯	◯	
Have you ever felt you needed a drink first thing in the morning?	◯	◯	

DIET:

Do you follow any special diet?	
Have you been on any special diets in the past?	
Describe your typical breakfast:	
Lunch:	
Dinner:	
Snacks:	
Can you eat all consistency foods?	
Do you take any nutrition supplements?	
Are there any specific foods you avoid, and if so, why?	

FUNCTIONAL HISTORY: Do you need help with any of the following:

Task	No help	A little help	Moderate help	Full assistance
Turning or sitting up in bed	◯	◯	◯	◯
Moving from bed to chair	◯	◯	◯	◯
Walking	◯	◯	◯	◯
Upper body dressing	◯	◯	◯	◯
Lower body dressing	◯	◯	◯	◯
Toileting	◯	◯	◯	◯
Bathing	◯	◯	◯	◯
Walking up stairs or outside	◯	◯	◯	◯
Driving	◯	◯	◯	◯
Buying food	◯	◯	◯	◯
Making meals	◯	◯	◯	◯
Feeding yourself	◯	◯	◯	◯
Managing medications	◯	◯	◯	◯
Managing finances	◯	◯	◯	◯

Do you have/ use any medical equipment or supplies? (circle or check if applies)

☐	Pantiliner or pad	☐	Cane	☐	Home Oxygen	☐	Thermometer
☐	Depends	☐	Walker	☐	CPAP or BiPAP	☐	Home Blood pressure cuff
☐	Glasses/Contacts	☐	Wheelchair	☐	Glucometer	☐	Oximeter
☐	Dentures	☐	Powerchair / Scooter	☐	Hearing Aid	☐	Scale