**HEALTH HISTORY QUESTIONAIRRE**

**Full Name:**

**Name You Prefer to be Called By (Mr, Mrs, First or Last Name, Nickname etc):**

**Address:**

**Primary Phone Number:  
Birthday:**

**Ethnicity:**

**Insurance Name:**

**Insurance ID & Group Number, Effective Date:**

**Preferred Email:**

**Emergency Contact Name/Phone Number:**

**Preferred Local Hospital System:**

**Pharmacy Name/Number/Fax:**

**Height:**

**Usual Weight:**

**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?

**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.

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

**HISTORY OF PRESENT ILLNESS:** What is your most concerning health problem? What measures have you taken so far to address it (treatments, medications, specialists seen).

**REVIEW OF SYSTEMS:** Please list any symptoms that bother you, from head to toe. For example – dry eyes, skin rash on arm, heartburn after meals, back pain etc.)

GENERAL (Weight, sleep energy level etc):

SKIN:

HEAD, NECK:

EARS, EYES, THROAT:

RESPIRATORY:

CARDIAC:

GASTROINTESTINAL:

GENITAL/URINARY:

MUSCULOSKELETAL:

NEUROLOGIC:

PSYCHIATRIC:

FEET:

OTHER:

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

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

**REPRODUCTIVE HEALTH HISTORY:** Do you have children? If you have a uterus, have you ever been pregnant? How many pregnancies have you had? Have you experienced abortions, spontaneous or elective? Do you have any concerns about your fertility or about your childbirth experiences? If you have female organs, at what age did you begin periods? Describe their frequency and any related symptoms). Are you currently sexually active? Do you take any steps to prevent pregnancy?

**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.

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

**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 for each. \*\*\*\*

**SOCIAL HISTORY:** Please notewhere you were born, your family race/ethnicity background, your first language, your relationship or marriage history. Do you have children, and if so what are their ages & health status? What type of work you have done? Describe what you do in your free time.

**RECREATIONAL DRUG USE:** Do you smoke (how many packs per day, year started & year quit)? How much alcohol you drink per day or week now and in the past & types? Do you, or have you used marijauna for recreation or medicinal purposes? Have you used any other types of recreational drugs?

**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? Have you ever been formally diagnosed with these condition, or required the care of a psychiatrist for them either in clinic or in the hospital?

**SEXUAL HEALTH HISTORY**: Do you have any question or concern about your gender identity? In your intimate relationships, do you favor partners who are male, female or both? Do you have any questions about your sexual health? Do you think you are at risk for HIV?

**SPIRITUAL HISTORY:** Is spiritual faith important to you? Is there a particular religious faith or teaching in which you participate? If so, is there a clergy person or spiritual leader who you would want contacted in the event of a serious illness?

**DIET**: What kinds of foods do you usually eat for breakfast, lunch or dinner. Can you eat all consistency foods? Do you take any nutrition supplements? Are there any specific foods you avoid, and if so, why?

**FAMILY HISTORY:** Please note your first degree family member and any health conditions they have had. Also note of there are any health conditions which have occurred in multiple family members.

**BIRTH & CHILDHOOD HISTORY**: Describe what you know about your own birth. Was it a vaginal or surgical delivery? Did your mother have any health conditions or exposures during pregnancy or delivery? These might include smoke, recreational drug use, or medicinal drug use such as antibiotics, epilespsy drugs etc. How would you describe your childhood?

**EXPOSURE HISTORY**: Have you ever been exposed to chemicals, irritants or pollutants in the past? Examples might include: living in a home with lead based paint, having mercury dental fillings, being exposed to a water damaged building with mold, living in an area exposed to pesticides or radiation, or working in a place with chemicals, animals, or radiation. Have you been exposed to the outdoors, such as hiking or camping, and been exposed to tick bites that you know of?

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

Eye Exam

Dental Exam

Hearing Exam

EKG

Colonoscopy

Flu Shot

Tetanus shot

Pneumonia shot

Shingles shot

Mammogram for females

Pap Smear for females

PSA (prostate lab test) for males

Sleep study

Pulmonary Function Test

Echocardiogram

**SAFETY CONCERNS**:

Do you always wear a seat belt when you drive? Yes No

Do you always wear a bike helmet? Yes No

Do you think you are at risk of HIV or sexually transmitted disease? Yes No

Do you keep firearms in your home? Yes No

If so, are they stored in a locked place? Yes No

Do you have working smoke detectors?

So you have a working carbon monoxide detector?

Do you feel safe in your neighborhood? Yes No

Is there anyone in your life now who says abusive things to you or has physically harmed you? Yes No

Is there anyone in your past who said abusive things to you or physically harmed you? Yes No

Is there any one using your money without your permission? Yes No

Do you have problems with walking or falls? Yes No

Do you or anyone in your life have concerns about your driving safely? Yes No

**FUNCTIONAL HISTORY:** Do you need help with any of the following: transferring yourself from a bed to a chair, walking, travelling by car. Upper or lower body dressing, bathing. Buying food, making meals or feeding yourself. Managing your medications or finances. Do you have any problems with bowel or bladder continence? Do you use any medical equipment at home (CPAP machine, oxygen, walker, glucometer etc).

**ADVANCE DIRECTIVES**: Please list who you would want called in the event of an emergency. Also list who you would want to make decisions for you if you are unable to speak for yourself. Do you have an advance directive? If so, please bring a copy for your electronic medical record. This can be submitted electronically by email or by paper for scanning into your record.

Please list the name and phone number of any other individuals who you wish to be allowed access to your health information in the event of serious health condition, such as a trusted close friend or first degree family members. Indicate their relationship to you.