Stellar Medical Group
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Health History Questionnaire

Last Name:	**First Name:**	**DOB:**
Previous or referring doctor:	**Date of last physical exam:**	

The reason(s) for today's visit

PERSONAL HEALTH HISTORY

Immunizations (Include approximate year or age)	☐ Tetanus	☐ Pneumonia/Pneumovax	☐ Hepatitis A
	☐ Influenza (Flu)	☐ Prevnar 13	☐ Hepatitis B
	☐ Gardasil (HPV)	☐ Shingles vaccine/Zostavax	

Past or Present Medical History: (check all that apply to you)

☐ Alcohol/ Drug problem	☐ Emphysema/COPD	☐ Liver Disease	☐ Blood Clots
☐ Anemia	☐ Heart – Attack	☐ Osteoporosis Prostate	☐ Peripheral Artery Disease
☐ Anxiety	☐ Heart–Coronary Artery Dis.	☐ problem	☐ Neuropathy
☐ Arthritis	☐ Heart- Heart Failure/ CHF	☐ Psychiatric- Depression	☐ Sleep Apnea
☐ Asthma	☐ High Blood Pressure	☐ Psychiatric Disorder--other	☐ Heart Murmur
☐ Atrial Fibrillation	☐ High Cholesterol	☐ Seizure Disorder	☐ Migraines
☐ Dementia	☐ Hypothyroidism (low)	☐ Stroke	☐ Hepatitis
☐ Diabetes	☐ Hyperthyroidism (high)	☐ Ulcers of the Stomach	☐ Diverticulosis
☐ Cancer— Type:	☐ Kidney Disease	☐ STD/ sexual infection	☐ Colon Polyps
		☐ Abnormal Pap Test	☐ Positive TB test

Surgeries (Include Year or Age at time of surgery)

☐ Appendectomy	☐ Tonsillectomy Hernia	☐ C-Section (Cesarean)
☐ Cardiac Bypass (CABG)	☐ Repair Prostate	☐ Hysterectomy- Partial
☐ Cardiac Angioplasty/Stent	☐ Surgery Vasectomy	☐ Hysterectomy- Total
☐ Gallbladder Laparoscopic	☐ Cataract Surgery: ☐ Left ☐ Right	☐ Tubal Ligation
☐ Gallbladder Open		☐ Breast Surgery: ☐ Left ☐ Right
☐ Orthopedic (type):		
☐ Other Surgery:		

Name:_____ DOB:_____ Date:_____

Screening Tests	Approx Date:			Approx Date:	
Cholesterol Test		☐ Normal ☐ Abnormal	Pap Smear		☐ Normal ☐ Abnormal
Colonoscopy		☐ Normal ☐ Abnormal	Mammogram		☐ Normal ☐ Abnormal
Prostate Test		☐ Normal ☐ Abnormal	Bone Density Test		☐ Normal ☐ Abnormal
Dental Exam		☐ Normal ☐ Abnormal			
Eye Exam		☐ Normal ☐ Abnormal ☐ Glasses ☐ Contacts ☐ Cataracts			

MEDICATIONS: List prescribed and over-the-counter medications.		
DRUG NAME:	DOSE & DIRECTIONS:	REASON:

ALLERGIES/ REACTIONS to Medications:	
DRUG NAME:	REACTION/ COMMENTS:
LIST ANY FOOD OR ENVIRONMENTAL ALLERGIES AND REACTIONS:	

SEXUAL HEALTH			
☐ Sexually active	☐ Not currently sexually active	☐ Never sexually active	# partners in past year:
History of Sexually Transmitted Infection ? ☐ No ☐ Yes Type/date:			
Current contraception method:		Previous methods:	
# children:	**For Women:** (# pregnancies:) (# miscarriages:) (# abortions:)		

Name:_____ DOB:_____ Date:_____

HEALTH HABITS AND PERSONAL SAFETY

Alcohol	Do you drink alcohol? ☐ No ☐ Yes : ☐ 0-1 time/month ☐ 2-4 times/month ☐ every week	
	Each week, how many: Servings of beer? Glasses of wine? Shots/mixed drinks?	
	When did you last have more than 4 drinks in one day? _____	
	Do you feel you should cut down on drinking?	☐ Yes ☐ No
	Do people annoy you by nagging about your drinking?	☐ Yes ☐ No
	Have you ever felt guilty about drinking?	☐ Yes ☐ No
	Have you ever had a morning drink to steady your nerves?	☐ Yes ☐ No

Drugs	Have you used recreational or street drugs within the last 2 years?	☐ Yes ☐ No
	Have you ever used recreational drugs with a needle?	☐ Yes ☐ No

Personal Safety	Do you wear seatbelts?	☐ Yes ☐ No
	Do you have frequent falls?	☐ Yes ☐ No
	Does your house have a working smoke detector?	☐ Yes ☐ No
	Do you experience conflicts in your relationships that take the form of verbally threatening behavior, mental abuse, physical abuse or sexual abuse?	☐ Yes ☐ No

FAMILY HEALTH HISTORY

Family Member			Age	MEDICAL CONDITIONS (Indicate Healthy or: diabetes, high blood pressure, cholesterol, heart disease, stroke, cancer &type)
Mother		☐ Living ☐ Deceased		
Father		☐ Living ☐ Deceased		
Grandmother *Mother's Side*		☐ Living ☐ Deceased		
Grandfather *Mother's Side*		☐ Living ☐ Deceased		
Grandmother *Father's Side*		☐ Living ☐ Deceased		
Grandfather *Father's Side*		☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
		☐ Living ☐ Deceased		
		☐ Living ☐ Deceased		

Reviewed By: _____ Date:_____