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| HEALTH HISTORY - ADULT |
| All questions contained in this questionnaire are strictly confidential and will become part of your medical record. |
| Name (Last, First, M.I.): |       | [ ]  M [ ]  F | DOB: |       |
| Marital status: | [ ]  Single [ ]  Partnered [ ]  Married [ ]  Separated [ ]  Divorced [ ]  Widowed |
| Referred by:       |  | Date of last physical exam: |       |
|  |
| PERSONAL HEALTH HISTORY |
|  |
| Childhood illness: | 🞎 Measles 🞎 Mumps 🞎 Rubella 🞎 Chickenpox 🞎 Rheumatic Fever 🞎 Polio 🞎 Other |
| Immunizations and | [ ]  Tetanus |       | [ ]  Pneumonia |       |
|  | [ ]  Hepatitis |       | [ ]  Chickenpox |       |
|  | [ ]  Influenza |       | [ ]  MMR       |  |
| List any medical problems  |
|       |
|  |
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|  |
| Surgeries |
| Year | Type of surgery | Recovery time |
|       |       |  |
|       |       |  |
|       |       |  |
|       |       |  |
|       |       |  |
| Other hospitalizations |
| Year | Reason | Recovery time |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

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| List all prescribed drugs and over-the-counter drugs, such as vitamins and supplements |
| Name | Strength | Frequency Taken |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| Allergies to medications |
| Name  | Reaction  |
|       |       |
|       |       |
|       |       |
|  |
| HEALTH History CONT’D |
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| Exercise | [ ]  Sedentary (No exercise) |
| [ ]  Mild exercise (i.e., climb stairs, walk 3 blocks, golf) |
| [ ]  Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) |
| [ ]  Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) |
| Diet | Are you dieting? | [ ]  | Yes | [ ]  | No |
| If yes, are you on a physician prescribed medical diet? | [ ]  | Yes | [ ]  | No |
| Favorite foods/cravings? |
| Rank salt intake | [ ]  Hi | [ ]  Med | [ ]  Low |
| Rank fat intake | [ ]  Hi | [ ]  Med | [ ]  Low |
| Caffeine | 🞎 None | [ ]  Coffee | [ ]  Tea | [ ]  Cola |
| # of cups/cans per day?       |
| Alcohol | Do you drink alcohol? | [ ]  | Yes | [ ]  | No |
| How many drinks do you have per week? |
| Are you or have you ever been prone to “binge” drinking? | [ ]  | Yes | [ ]  | No |
| Tobacco | Do you use tobacco? | [ ]  | Yes | [ ]  | No |
| [ ]  Cigarettes – pks./day       | [ ]  Chew - #/day       | [ ]  Pipe - #/day       | [ ]  Cigars - #/day       |
| [ ]  # of years       | [ ]  Or years quit       |
| Drugs | Do you currently use recreational or street drugs? | [ ]  | Yes | [ ]  | No |

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| FAMILY HEALTH HISTORY |
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|  | Age | Significant Health Problems |  | Age | Significant Health Problems |
| Father |       |       | Children | [ ]  M[ ]  F |  |       |
| Mother |       |       | [ ]  M[ ]  F |  |       |
| Siblings | [ ]  M[ ]  F |  |       | [ ]  M[ ]  F |  |       |
| [ ]  M[ ]  F |  |       | [ ]  M[ ]  F |  |       |
| [ ]  M[ ]  F |  |       | GrandmotherMaternal |       |       |
| [ ]  M[ ]  F |  |       | GrandfatherMaternal |       |       |
| [ ]  M[ ]  F |  |       | GrandmotherPaternal |       |       |
| [ ]  M[ ]  F |  |       | GrandfatherPaternal |       |       |

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| MENTAL HEALTH |
|  |
| Is stress a major problem for you? | [ ]  | Yes | [ ]  | No |
| Do you feel depressed? | [ ]  | Yes | [ ]  | No |
| Do you have panic or anxiety attacks? | [ ]  | Yes | [ ]  | No |
| Do you have problems with eating or your appetite? | [ ]  | Yes | [ ]  | No |
| Do you cry frequently/easily? | [ ]  | Yes | [ ]  | No |
| Have you ever attempted suicide? | [ ]  | Yes | [ ]  | No |
| Do you have trouble sleeping? | [ ]  | Yes | [ ]  | No |
| Do you have recurring dreams? | [ ]  | Yes | [ ]  | No |

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| WOMEN ONLY |
|  |
| Age at onset of menstruation:       |
| Date of last menstruation:       |
| Period every       days |
| Heavy periods, irregularity, spotting, pain, or discharge? | [ ]  | Yes | [ ]  | No |
| Number of pregnancies       Number of live births       |
| Are you pregnant or breastfeeding? | [ ]  | Yes | [ ]  | No |
| Have you had a D&C, hysterectomy, or Cesarean? | [ ]  | Yes | [ ]  | No |
| Any urinary tract, bladder, or kidney infections within the last year? | [ ]  | Yes | [ ]  | No |
| Any blood in your urine? | [ ]  | Yes | [ ]  | No |
| Any problems with control of urination? | [ ]  | Yes | [ ]  | No |
| Any hot flashes or sweating at night? | [ ]  | Yes | [ ]  | No |
| Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? | [ ]  | Yes | [ ]  | No |
| Experienced any recent breast tenderness, lumps, or nipple discharge? | [ ]  | Yes | [ ]  | No |
| Date of last pap and rectal exam?       |
|  |
| MEN ONLY |
|  |
| Do you usually get up to urinate during the night? | [ ]  | Yes | [ ]  | No |
| If yes, # of times       |
| Do you feel pain or burning with urination? | [ ]  | Yes | [ ]  | No |
| Any blood in your urine? | [ ]  | Yes | [ ]  | No |
| Has the force of your urination decreased? | [ ]  | Yes | [ ]  | No |
| Have you had any kidney, bladder, or prostate infections within the last 12 months? | [ ]  | Yes | [ ]  | No |
| Do you have any problems emptying your bladder completely? | [ ]  | Yes | [ ]  | No |
| Any difficulty with erection or ejaculation? | [ ]  | Yes | [ ]  | No |
| Any testicle pain or swelling? | [ ]  | Yes | [ ]  | No |
|  |
| OTHER |
|  |
| Check if you have, or have had, any symptoms in the following areas to a significant degree and explain. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| [ ]  | Skin       | [ ]  | Chest/Heart       | [ ]  | Recent changes in:       |
| [ ]  | Head/Neck       | [ ]  | Back       | [ ]  | Weight       |
| [ ]  | Ears       | [ ]  | Intestinal       | [ ]  | Energy level       |
| [ ]  | Nose       | [ ]  | Bladder       | [ ]  | Ability to sleep       |
| [ ]  | Throat       | [ ]  | Bowel       | [ ]  | Other pain/discomfort:       |
| [ ]  | Lungs       | [ ]  | Circulation       |  |  |