G&K MEDICAL ASSOCIATES, P.C

G&K Medical Associates, P.C.
10450 W. McDowell Road, Suite 101
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Health History Questionnaire

All questions contained in this questionnaire are strictly **confidential** and will become part of your medical record.

Name: □ M □ F	Age:	DOB: / /
Please list any health and/or fitness goals:		
1. 2. 3.		
PERSONAL HEALTH HISTORY		
Illnesses (Check any that apply)		
□ High Blood Pressure	□ Hepatitis B or C	
□ Coronary Artery or Heart Disease	□ Gall Stones / Gall Bladder Surgery	
□ Cardiac Arrhythmia (irregular heart rhythm)	□ Irritable Bowel Syndrome (IBS)	
□ Heart Murmur	□ Inflammatory Bowel Disease (Crohn's, UC)	
□ Heart Valve Abnormality	□ Gastric Reflux/GERD	
□ Asthma / Bronchitis	□ GI Ulcer (esophageal, gastric or duodenal)	
□ Seasonal Allergies	□ Frequent Urinary Tract Infections (Bladder or Kidney)	
□ Anemia	□ Kidney Stones	
□ Blood Disease / Disorder	□ Multiple Sclerosis	
□ Deep Venous Thrombosis	□ Cancer or Tumor – Type:	
□ Fibromyalgia	□ Depression	
□ Loss of Consciousness / Head Injury	□ Anxiety	
□ Seizures	□ Eating Disorder	
□ Thyroid Disorder (hypothyroid, hyperthyroid, Hashimoto's or Graves)	□ Bipolar Disorder	
□ Diabetes Type 1 (last HBA1C =)	□ Obsessive Compulsive Disorder (OCD)	
□ Diabetes Type 2 (last HBA1C =)	□ Overtraining Syndrome	
□ Systemic Lupus Erythematous (SLE)	□ ADD/ADHD	
□ Rheumatoid Arthritis	□ Alcohol / Substance Abuse	
□ Chronic Fatigue Syndrome	□ Frequent Severe Headaches / Migraines	

List any other medical condition not specified above:
1.
2.
3.

Surgeries / Hospitalizations or Inpatient treatment		
Year	Reason	Hospital

List ALL medications (include prescriptions, over-the-counter medications, vitamins, supplements, herbal remedies, etc.)				
Name of Drug/Supplement	Strength (mg, etc.)	Times per Day	Start Date/Year	Prescribed By

Allergies to medications, foods, or others (latex, insect bites, environmental)	
Name	Reaction

HEALTH HABITS AND PERSONAL SAFTEY		
ALL ANSWERS IN THE QUESTIONAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL		
Occupation	Occupation:	Employer:
	Hours per week:	Work stress level: high medium low
Caffeine, Alcohol & Tobacco	# of cups/cans caffeinated beverages per day? # of alcoholic drinks per week? Current or past tobacco use: How many years smoked? _____ When quit? _____	
Exercise	□ I exercise regularly □ I'm training for an event Event:	How long have you consistently exercised? ____ Months ____ Years
	Check all that you participate in: □ Run □ Walk □ Bike □ Swim □ Kayak □ Row □ Hike □ Cross/Elliptical Trainer □ Other Activity:	
	# of cardio workouts/week:	Intensity: high medium low Duration: - Minutes/session

	# of strength workouts/week:	# of sets:	# of reps:	
Dietary	How would you describe your nutritional intake: #meals/day ____ #snacks/day ____			
	□ Regular	□ Diabetic	□ Low Carbohydrate	□ High Protein
	□ Weight Reduction	□ Vegan	□ Low Fat	□ Low Sodium
	□ Other	□ Weight Gain	□ Lactose Free	□ Gluten Free

FAMILY HEALTH HISTORY

List which biologic relatives (parents, grandparents, siblings, aunts, uncles, etc.) have the following:

Alcohol/Drug Abuse		High Blood Pressure	
Asthma		Intestinal Disorder	
Bleeding Disorder		Kidney Disease	
Blood Clots		Mental Illness	
Cancer		Migraine Headaches	
Depression		Neurologic Disorder	
Diabetes		Premature Death	
Eating Disorder		Stroke	
Gynecologic Problems		Suicide Attempt	
Heart Disease/Attack		Thyroid Disease	
High Cholesterol		Other	

HEALTH MAINTENANCE

Provide date of most recent exams/procedures (if applicable):

Physical Exam:	Colon Screening:	EKG:	Blood Work:
Cardiac stress test:	Pap (women):	Mammogram (women):	DEXA/Bone density:
Heart Scan:	Chest X-Ray:		Tetanus Booster:

WOMEN ONLY

Age at onset of menstruation		Date of last menstruation	

Average period occurs every _____ days and lasts approximately _____ days.		
Heavy periods, irregularity, spotting, pain or discharge?	□ Yes	□ No
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breast feeding?	□ 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 the time of your period?	□ Yes	□ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	□ Yes	□ No
Do you perform monthly self-breast examinations?	□ Yes	□ No

MEN ONLY

Do you usually get up to urinate frequently during the night?	□ Yes	□ No
Do you feel pain or burning with urination?	□ Yes	□ No
Any blood in your urine?	□ Yes	□ No
Do you have burning discharge from penis?	□ Yes	□ No
Has the force of your urination decreased or do you have problems emptying your bladder completely?	□ Yes	□ No

Any difficulty with erection or ejaculation?	□ Yes	□ No
Any testicle pain or swelling?	□ Yes	□ No

REVIEW OF SYSTEMS				
CHECK IF YOU CURRENTLY DEXPERIENCE ANY SYMPTOMS IN THE FOLLOWING AREAS TO A SIGNIFICANT DEGREE.				
General	□ Loss of Appetite □ Insomnia	□ Fever or Chills □ Sweats	□ Mental fogginess □ Weight Gain	□ Fatigue □ Weight Loss
Eyes	□ Blurred Vision □ Vision Loss	□ Double Vision □ Eye Irritation/ Itching	□ Eye Pain □ Glasses	□ Eye Discharge □ Contacts
Ears, Nose and Throat	□ Decreased Hearing □ Pain Swallowing	□ Ringing in Ears □ Nose Bleeds	□ Ear Pain □ Dental Devices	□ Hoarseness □ Brush & Floss Daily
Cardiovascular/ Respiratory	□ Chest Pain at Rest □ Cough	□ Chest Pain with Activity □ Wheezing	□ Peripheral Edema □ Shortness of Breath	□ Palpitations □ Bloody Sputum
Gastrointestinal	□ Abdominal Pain □ Constipation	□ Nausea □ Bloody or Dark Stool	□ Vomiting □ Blood in Vomit	□ Diarrhea □ Reflux / Heartburn
Genitourinary	□ Painful Urination □ Frequent Urination	□ Blood in Urine □ Change in Urine Color	□ Difficulty Urinating □ Increased Night Urination	□ Incontinence
Musculoskeletal	□ Back Pain □ Muscle Twitching	□ Joint Pain □ Muscle Aches	□ Joint Swelling □ Broken Bones	□ Muscle Weakness □ Stress Fractures
Skin	□ Dry Skin □ Acne	□ Itching □ Unwanted Hair Growth	□ Rash	□Suspicious Mole
Neurological	□ Dizziness	□ Weakness	□ Tremors	□ Numbness
Psychiatric	□ Depression	□ Anxiety	□ Self Harm Behavior	□ Suicidal Thoughts
Endocrine	□ Cold Intolerance	□ Heat Intolerance	□ Increased Thirst	□ Weight Change
Hematologic/ Lymphatic	□ Abnormal bruising	□ Easy Bleeding	□ Enlarged Lymph Nodes	

CERTIFICATION

The above information is true to the best of my knowledge.

X_____ Date: _____
Patient (Signature)

X_____ Date: _____
Legal Guardian/Authorized Individual Signature (Required if under 18 years of age)

Staff: This health history questionnaire was reviewed by _____ (physician) on _____ (date).