G&K MEDICAL ASSOCIATES, P.C.

10450 W. McDowell Road, Ste 101
Avondale, AZ 85392

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
☐ Coronary Artery or Heart Disease
☐ Cardiac Arrhythmia (irregular heart rhythm)
☐ Heart Murmur
☐ Heart Valve Abnormality
☐ Asthma / Bronchitis
☐ Seasonal Allergies

☐ Anemia
☐ Blood Disease / Disorder
☐ Deep Venous Thrombosis
☐ Fibromyalgia
☐ Loss of Consciousness / Head Injury
☐ Seizures
☐ Thyroid Disorder (hypothyroid, hyperthyroid, Hashimoto's or Graves)
☐ Diabetes Type 1 (last HBA1C =)
☐ Diabetes Type 2 (last HBA1C =)
☐ Systemic Lupus Erythematous (SLE)
☐ Rheumatoid Arthritis
☐ Chronic Fatigue Syndrome

☐ Hepatitis B or C
☐ Gall Stones / Gall Bladder Surgery
☐ Irritable Bowel Syndrome (IBS)
☐ Inflammatory Bowel Disease (Crohn's,UC)
☐ Gastric Reflux/ GERD
☐ GI Ulcer (esophageal, gastric, or duodenal)
☐ Frequent Urinary Tract Infections (Bladder or Kidney)
☐ Kidney Stones
☐ Multiple Sclerosis
☐ Cancer or Tumor – Type:
☐ Depression
☐ Anxiety
☐ Eating Disorder
☐ Bipolar Disorder

☐ Obsessive Compulsive Disorder (OCD)
☐ Overtraining Syndrome
☐ ADD/ADHD
☐ Alcohol / Substance Abuse
☐ Frequent Sever Headaches / Migraines

List any other medical conditions 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, food, or others (latex, insect bites, environmental)

Name	Reaction

HEALTH HABITS AND PERSONAL SAFETY

ALL ANSWERS IN THE QUESTIONARIE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Occupation:_____Employer:_____

Hours/week:_____Work stress level: high medium low

Caffeine, Alcohol and Tobacco

# of cups/cans caffeinated beverage per day?_____

# of alcoholic drinks per week?_____

Current or past tobacco use: How many years smoked?_____
When quit?_____

Exercise

☐ I exercise regularly

How long have you consistently exercised?

☐ I'm training for an event

_____Months _____Years

Event: _____

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, ect.) 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		Tyrod Disease	
High Cholesterol		Other	

HEALTH MAINTENANCE

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

Physical Exam: _____ Colon Screening: _____ EKG: _____

Cardiac stress test: _____ Pap (Women): _____

Mammogram (Women): _____ Heart Scan: _____ Chest X-Ray: _____

Blood Work: _____ DEXA/Bone density: _____

Tetanus Booster: _____

WOMEN ONLY

Age at onset of menstruation: _____ Date of last menstruation: _____

Average period occurs every _____ days and last approximately _____ days.

- Heavy periods, irregularity, spotting, pain, or discharge? ☐ Yes ☐ No
- Number of pregnancies _____ Number of births _____ ☐ Yes ☐ No
- 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 seating 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 THE BOX F YOU CURRENLY EXPERIENCE ANY SYMPTOMS IN THE FOLLOWING AREAS TO A SIGNIFICANT DEGREE.

General	☐ Loss of Appetite ☐ Insomnia	☐ Fever/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 ONLY

This health history questionnaire was reviewed by _____ (provider) on _____ (date).