Patient Name:______________________________

HEALTH HISTORY QUESTIONAIRE:

Please list last Primary Care Physician or Facility: ____

Please list when and where you last completed the following:

Name:	**Date:**	**MD/PA/APRN or Facility**
Physical Examination	____________	________________________
Dental Exam	____________	________________________
Eye Exam	____________	________________________
Diabetic eye exam	____________	________________________
Tetanus vaccine	____________	________________________
Flu Vaccine	____________	________________________
Pneumococcal Vaccine	____________	________________________
Colonoscopy	____________	________________________
Pap Smear	____________	________________________
Mammogram	____________	________________________
DEXA scan	____________	________________________

PAST MEDICAL HISTORY

Please **check** ☑ **any** conditions you have been diagnosed with by a **Medical Doctor:**

Condition	
AAA(Abdominal Aortic Aneurism)	
Abnormal Fasting Blood Sugar Test	
Acne	
ADHD	
Atrial Fibrillation	
Aortic Insufficiency	
Alcohol Abuse	
Allergic Rhinitis	
Alzheimer's DS	
Anemia	
Anxiety Disorder	
Asthma	
Bipolar Disorder	
Benign Prostatic Hypertrophy	
Coronary Artery Disease	
Cardiac Arrhythmias	
Cancer: **Type**:__________________ **Type**:__________________	
Cardiomyopathy	
Carotid Stenosis	
Carpal Tunnel	
Cataract	
Congestive Heart Failure	
Cholelithiasis (Gallstones)	
Chronic Pain Syndrome	
Cirrhosis of Liver	
Chronic Kidney Disease	
Colon Polyps	
COPD\Emphysema	
Crohn's Disease	
Cushing Disease	
CVA/Stroke	
Disc Disease Neck	

Condition	
Disc Disease Lower Back	
Depression	
Diverticulosis	
Degenerative Joint Disease Body Part:	
Diabetes – Type 1	
Diabetes – Type 2	
Down's Syndrome	
Drug Abuse	
Deep Venous Thrombosis	
Abnormal Cholesterol Levels	
Eczema	
Endometriosis	
Erectile dysfunction	
Fibrocystic Breast Disease	
Gastro esophageal Reflux Ds	
Glaucoma	
Gout	
Guillain-Barre' Syndrome	
Hepatitis C	
Heart Attack/MI	
Heart Murmur	
HIV	
Hodgkin's Disease	
Hard of Hearing	
High Blood Pressure	
Polio	
Hyperactive Bladder	
Hyperparathyroidism	
Hyperthyroidism	
Hypothyroidism	
Irritable Bowel Syndrome	
Insomnia	
Internal Derangement of Knee	
Kidney Stones	
Lower Back Pain	
Lupus	

Condition	
Migraine Headaches	
Multiple Sclerosis	
Neck Pain	
Osteoarthritis	
Obesity	
Osteoporosis	
Ovarian Cystic Disease	
Peripheral Artery Disease	
Pancreatitis, Chronic	
Panic Attacks	
Parkinson Disease	
Peripheral Neuropathy	
Pre Menstrual Syndrome	
Positive PPD/TB Test	
Psoriasis	
Post Traumatic Stress Disorder	
Peptic Ulcer Disease	
Pulmonary Hypertension	
Peripheral Vascular Disease	
Rheumatoid Arthritis	
Rosacea	
Rotator Cuff Syndrome	
Schizophrenia	
Scoliosis	
Seizure Disorder	
Sinusitis, Chronic	
Sleep Apnea	
Spinal Stenosis	
Subarachnoid Hemorrhage	
Subdural Hematoma	
TIA (Stroke)	

PAST SURGICAL HISTORY

Please **check** ☑ **any** surgeries completed and list the year when done.

		Year			Year
A/C Separation Repair			Kidney Stone Crushing		
Aneurysm Coil			Abdominal Surgery		
Appendix Removed			Laparoscopy		
Breast Augmentation			Breast Removed		
Breast Reduction			Melanoma Removed		
Bilateral Tubal Ligation			Kidney Removed		
C Section			Surgery for Bone Fracture Using pins or plates		
Coronary Arterial Bypass Graft			Pacemaker/Defibrillator		
Cardiac Valve Surgery			Prostate Removed		
Carotid Endarterectomy			Cardiac Angioplasty/Stent		
Carpal Tunnel Surgery			Rotator Cuff Repair *circle one (right or left)		
Gall Bladder Removed			Spinal Surgery: *Circle One: L-Spine /T-Spine /C-Spine		
Ectopic Pregnancy			Spleen Removed		
Gastric Bypass			Tonsils Removed		
Hemorrhoid Removal			Total Abdominal Hysterectomy		
Hernia Repair *Circle One: Umbilical / Abdominal / Inguinal / Hiatal			Thoracotomy (Chest Incision)		
Hip Replacement			Thyroid Removed		
Hysterectomy			Transurethral Resection of Prostate		
Knee, Open Procedure *circle one (right or left)			Vasectomy		
Knee Arthroscopy *circle one (right or left)			Vein Stripping		
Knee Replacement *circle one (right or left)					

FAMILY HISTORY

☐ **I'M ADOPTED** (SKIP TO CHILDREN QUESTION)

MOTHER:	**FATHER:**
Alive Year Born ____	Alive Year Born ____
If Deceased Age when passed____	*If Deceased* Age when passed____
Cause of death_______________	Cause of death_______________
History: **(Circle)** diabetes / heart disease / dementia	History: **(Circle)** diabetes / heart disease / dementia
high blood pressure / stroke / COPD / cancer-type:__________	high blood pressure / stroke / COPD / cancer-type:__________

SIBLINGS ☐Yes ☐ No ☐ Unknown

Brother(s) How many____ (**Circle**) diabetes / heart disease / high blood pressure / stroke / COPD / dementia / cancer

Sister (s) How many____ (**Circle**) diabetes / heart disease / high blood pressure / stroke / COPD / dementia / cancer

***If deceased**, reason and age at time of death:*

#1: From ________________________ Age ______ ☐ Sister ☐ Brother

#2: From ________________________ Age ______ ☐ Sister ☐ Brother

#3: From ________________________ Age ______ ☐ Sister ☐ Brother

#4: From ________________________ Age ______ ☐ Sister ☐ Brother

CHILDREN ☐Yes ☐ No

How many male ____ Health Issues:_________________________________

How many female ____ Health Issues:_________________________________

SOCIAL HISTORY

Please **check** ☑ applicable box and answer:

Cigarette Smoker: ☐ **Never**(skip to next box)

☐ **Currently smoking** Cigarettes per day?_____ Total years smoking?______

☐ **Past** Cigarettes per day?_____ Total years smoked?______ Year quit? _____

Non-prescription/recreation drug use ☐ **Never** (skip to next box)

☐ **Currently use** Please list types using:____

☐ **Used in the past** Please list types used:____

Are you currently: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

What year were you married/divorced/widowed? _____________

Current Employment Status:
☐Unemployed ☐ Disabled ☐Student ☐Retired ☐Self-employed ☐ Minor

Employed as:____

Is there a firearm in your home? ☐ Yes ☐ No

Do you regularly drink alcohol? ☐ Yes ☐ No

-How many drinks ________ per (**circle**) day / week / month