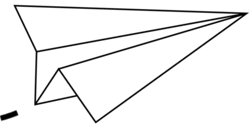
Health History Questionnaire



PATIENT INFORMATION – *Please Print*

Legal Name (First, Middle, Last):____Suffix: __________

SSN:________________Date of Birth:____________Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Home Address:______________________________________City, ST, Zip: ______________________

Mailing Address:____________________________________City, ST, Zip: ______________________

Home Phone: _________________ Work Phone: _________________ Cell Phone: ________________

Email Address:________________________________*(This is part of your protected health record and will not be sold or spammed)*

Employer:______________________________________Occupation: ________________________

Gender: ❑ Male ❑ Female Race: ❑ White/Caucasian ❑ Other ❑ Black/African American First Language: ❑ English ❑ Other ❑ Spanish Ethnicity: ❑ Hispanic ❑ Non-Hispanic

EMERGENCY CONTACT – *Who may we contact in case of an emergency?*

Name:____Relationship to patient: _________________

Home Phone: _________________ Work Phone: _________________ Cell Phone: ________________

Personal Health History		Previous Surgical Procedures	
Please check past(P) or current(C) problems or conditions		Please check if you have had any of the following	
		Procedure	Year
P☐ C☐ Hypertension	P☐ C☐ Bowel/digestive problem	☐ Heart surgery	
P☐ C☐ High cholesterol	P☐ C☐ Atrial Fibrillation	☐ Carotid artery surgery	
P☐ C☐ Diabetes	P☐ C☐ Seizures	☐ Vascular surgery / stent	
P☐ C☐ Heart attack or angina	P☐ C☐ Headaches	☐ Abdominal aneurysm repair	
P☐ C☐ Irregular heart rhythm	P☐ C☐ Stroke	☐ Hysterectomy	
P☐ C☐ Congestive heart failure	P☐ C☐ Prostate problem	☐ Gallbladder removed	
P☐ C☐ Emphysema or chronic bronchitis	P☐ C☐ Breast problem P☐ C☐ Urinary tract infections	☐ Appendix removed	
P☐ C☐ Pneumonia	P☐ C☐ Arthritis	☐ Tonsillectomy	
P☐ C☐ Gastroesophageal reflux disease	P☐ C☐ Thyroid problem P☐ C☐ Bleeding disorder	☐ Joint replacement ☐ Hip ☐ Right ☐ Left	
P☐ C☐ Asthma	P☐ C☐ Addiction Issues	☐ Knee ☐ Right ☐ Left	
P☐ C☐ Osteoporosis/Osteopenia	P☐ C☐ Depression	☐ Spine Surgery ☐ Neck ☐ Back	
P☐ C☐ Cancer, Type:	P☐ C☐ Anxiety	☐ Breast cancer surgery	
P☐ C☐ Stomach ulcer	P☐ C☐ Mental Illness	☐ Prostate cancer surgery	
P☐ C☐ Kidney Disease, Type:	P☐ C☐ Other:	☐ Hernia	
P☐ C☐ Liver Disease, Type:		☐ Other: ____________________	

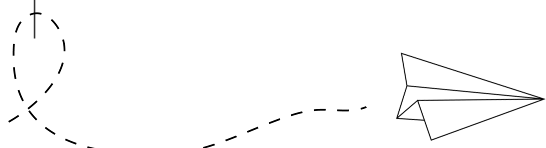
Health History Questionnaire - Page 2

Current Health Concerns			
Please check problems or conditions that you are CURRENTLY experiencing			
☐ Chest pain	☐ Rectal bleeding	☐ Eye pain	☐ Nervousness
☐ Shortness of breath	☐ Black/tarry stools	☐ Loss of vision	☐ Pain in testicles
☐ Wheezing	☐ Weight loss	☐ Double vision	☐ Loss of libido
☐ Cough	☐ Weight gain	☐ Memory loss	☐ Impotence
☐ Coughing up blood	☐ Loss of appetite	☐ Ringing in ears	☐ Breast pain
☐ Sore throat	☐ Difficulty swallowing	☐ Pain in ears	☐ Breast discharge
☐ Nasal congestion	☐ Diarrhea	☐ Nose bleeds	☐ Other (please describe below)
☐ Irregular heartbeat	☐ Constipation	☐ Hoarseness	
☐ Fast heartbeat	☐ Painful urination	☐ Easy bleeding	
☐ High blood pressure	☐ Blood in urine	☐ Easy bruising	
☐ Low blood pressure	☐ Urine frequency	☐ Rash	
☐ Lightheadedness	☐ Decrease in urine flow	☐ Changes in mole	**Females - Please complete**
☐ Dizziness/fainting	☐ Urine leakage	☐ Sore that won't heal	Menstrual flow:
☐ Abdominal pain	☐ Headaches, frequent	☐ Fatigue/lethargy	☐ Reg. ☐ Irreg. ☐ Pain/cramps
☐ Heartburn	☐ Hemorrhoids	☐ Insomnia	Days of flow __ Length of cycle__
☐ Indigestion	☐ Loss of strength	☐ Forgetfulness	1st day of last period___________
☐ Ankle swelling	☐ Balance problems	☐ Depression	☐ Pain or bleeding after sex
☐ Nausea	Pain, weakness, or numbness in		Number of pregnancies ________
☐ Vomiting	☐ Arms ☐ Hips	☐ Back	Miscarriages_________________
☐ Vomiting blood	☐ Legs ☐ Neck	☐ Shoulders	Birth control method __________
☐ Change in bowel habits	☐ Hands ☐ Feet	☐ Abdomen	Menopause ☐ Y ☐ N Age: _______

Family History			
Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			
Children			

Specifically, have any of your relatives had the following conditions:			
Condition	Relative	Condition	Relative
☐ Mental illness		☐ Chemical dependency	
☐ Diabetes		☐ Stroke	
☐ Thyroid Disease		☐ Arthritis	
☐ Pituitary Disease		☐ Dementia	
☐ Chrohn's/Colitis		☐ Hypertension	
☐ Cancer, Type: ___________________		☐ Other:	

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?



Health History Questionnaire - Page 3

Health Maintenance:								
Please check whether you have had the following preventive services and enter the year of the service								
Immunizations			Last Occurrence		Tests			Last Occurrence
Tetanus vaccine / Tdap	☐ Yes	☐ No			Pap smear/pelvic	☐ Yes	☐ No	
Pneumonia vaccine	☐ Yes	☐ No			Mammogram	☐ Yes	☐ No	
Influenza vaccine	☐ Yes	☐ No			Bone Density	☐ Yes	☐ No	
Shingles vaccine	☐ Yes	☐ No			Colonoscopy	☐ Yes	☐ No	
Hepatitis ☐ A ☐ B	☐ Yes	☐ No			Prostate test	☐ Yes	☐ No	
Guardasil (HPV)	☐ Yes	☐ No			Chest X-Ray	☐ Yes	☐ No	

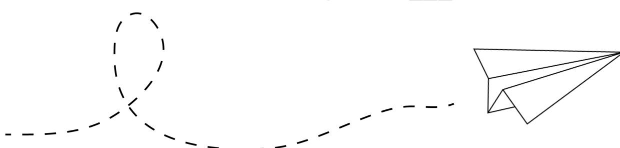
Hospital Admissions (excluding pregnancies):		
Date	Hospital	Reason for admission

Allergies:	
Please list any allergies to medications or foods	
Name	Symptom/Reaction

Medications:					
Please list any medications that you take including over the counter medications, herbs, and supplements.					
Name	Dose	Freq.	Name	Dose	Freq.

Pharmacy: ___________________________ **Phone**: ________________ **Store #**: _________________

Location Description: ____



Health History Questionnaire - Page 4

Specialty Providers:	
In order that we can best coordinate your care, please list any medical providers you see outside of this practice	
Cardiologist Name: ____ Phone: _________________________ Last Seen:__________	**Nephrologist** Name: ____ Phone: ______________________ Last Seen: __________
Ophthalmologist Name: ____ Phone: _________________________ Last Seen:__________	**Psychiatrist/Psychologist** Name: ____ Phone: ______________________ Last Seen: __________
Oncologist Name: ____ Phone: _________________________ Last Seen:__________	**Allergist** Name: ____ Phone: ______________________ Last Seen: __________
Urologist Name: ____ Phone: _________________________ Last Seen:__________	**Gynecologist** Name: ____ Phone: ______________________ Last Seen: __________
Gastroenterologist Name: ____ Phone: _________________________ Last Seen:__________	**Pulmonologist** Name: ____ Phone: ______________________ Last Seen: __________
Endocrinologist Name: ____ Phone: _________________________ Last Seen:__________	**Podiatrist:** _____________________ Name: ____ Phone: ______________________ Last Seen: __________

INSURANCE –

	Primary Insurance	Secondary Insurance
Company		
Policy #		
Group #		
Policy Holder's Name		
Relationship to Patient		

Patient Signature:____

Date:____