

HEALTH HISTORY QUESTIONNAIRE

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|---|--|---|------|
| Name (Last, First, M.I.): | | <input type="checkbox"/> M <input type="checkbox"/> F | DOB: |
| Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | | | |
| Referred by: | | Date of last physical exam: | |

PERSONAL HEALTH HISTORY

| | | | |
|---|------------------------------------|---|--|
| Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio | | | |
| Immunizations and dates to the best of your memory: | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Pneumonia | |
| | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Chickenpox | |
| | <input type="checkbox"/> Influenza | <input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i> | |

List any medical problems that have been previously diagnosed?

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Past or Future Scheduled Surgeries:

| Year | Reason | Hospital |
|------|--------|----------|
| | | |

Other hospitalizations (Medical, Psychiatric, Rehab, Nursing Home etc.)

| Year | Reason | Hospital |
|------|--------|----------|
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HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

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| Exercise | <input type="checkbox"/> Sedentary (No exercise) | | |
| | <input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | |
| | <input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) | | |
| | <input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) | | |
| Diet | Are you dieting? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

| | | | | | |
|------------------------|---|---------------------------------------|---------------------------------------|---|-----------------------------|
| | If yes, are you on a physician prescribed medical diet? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | # of meals you eat in an average day? | | | | |
| | Rank salt intake | <input type="checkbox"/> Hi | <input type="checkbox"/> Med | <input type="checkbox"/> Low | |
| | Rank fat intake | <input type="checkbox"/> Hi | <input type="checkbox"/> Med | <input type="checkbox"/> Low | |
| Caffeine | <input type="checkbox"/> None | <input type="checkbox"/> Coffee | <input type="checkbox"/> Tea | <input type="checkbox"/> Cola | |
| | # of cups/cans per day? | | | | |
| Alcohol | Do you drink alcohol? Include beer and wine. | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | How many drinks per week? | | | | |
| | Are you concerned about the amount you drink? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Have you considered stopping? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Have you ever experienced blackouts? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Are you prone to "binge" drinking? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Do you drive after drinking? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tobacco | Do you use tobacco? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | <input type="checkbox"/> Cigarettes – pks./day | <input type="checkbox"/> Chew - #/day | <input type="checkbox"/> Pipe - #/day | <input type="checkbox"/> Cigars - #/day | |
| | <input type="checkbox"/> # of years | <input type="checkbox"/> Or year quit | | | |
| Drugs | Do you currently use recreational or street drugs including marijuana? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Have you ever taken street drugs with a needle? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sex | Are you sexually active with men? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Are you sexually active with women? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Any discomfort with intercourse? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Other sexual concerns? | | | | |
| Personal Safety | Do you live alone? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Do you have frequent falls? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Do you have vision or hearing loss? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Do you have an Advance Directive or Living Will? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Would you like information on the preparation of these? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

FAMILY HEALTH HISTORY

| | AGE | SIGNIFICANT HEALTH PROBLEMS | | AGE | SIGNIFICANT HEALTH PROBLEMS |
|----------------|--|-----------------------------|-----------------|--|-----------------------------|
| Father | | | Children | <input type="checkbox"/> M <input type="checkbox"/> F | |
| Mother | | | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| Sibling | <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> M <input type="checkbox"/> F | |

| | | | | |
|--|--|---------------------------------------|--|--|
| <input type="checkbox"/> M <input type="checkbox"/> F | | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| <input type="checkbox"/> M <input type="checkbox"/> F | | Grandmother <i>Maternal</i> | | |
| <input type="checkbox"/> M <input type="checkbox"/> F | | Grandfather <i>Maternal</i> | | |
| <input type="checkbox"/> M <input type="checkbox"/> F | | Grandmother <i>Paternal</i> | | |
| <input type="checkbox"/> M <input type="checkbox"/> F | | Grandfather <i>Paternal</i> | | |

MENTAL HEALTH

| | | |
|---|------------------------------|-----------------------------|
| Is stress a major problem for you? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you feel depressed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you panic when stressed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have problems with eating or your appetite? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you cry frequently? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever attempted suicide? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever seriously thought about hurting yourself? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have trouble sleeping? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever been to a counselor? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

MEN ONLY

| | | |
|---|------------------------------|-----------------------------|
| Do you usually get up to urinate during the night? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, # of times _____ | | |
| Do you feel pain or burning with urination? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any blood in your urine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you feel burning discharge from penis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has the force of your urination decreased? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had any kidney, bladder, or prostate infections within the last 12 months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have any problems emptying your bladder completely? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any difficulty with erection or ejaculation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any testicle pain or swelling? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Date of last prostate and rectal exam? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

WOMEN ONLY

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|---|------------------------------|-----------------------------|
| Age at onset of menstruation: | | |
| Date of last menstruation: | | |
| Period every ____ days | | |
| Heavy periods, irregularity, spotting, pain, or discharge? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Number of pregnancies ____ Number of live births ____ | | |
| Are you pregnant or breastfeeding? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had a D&C, hysterectomy, or Cesarean? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any urinary tract, bladder, or kidney infections within the last year? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any blood in your urine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any problems with control of urination? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any hot flashes or sweating at night? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Experienced any recent breast tenderness, lumps, or nipple discharge? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Date of last pap and rectal exam? | | |

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

| | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> Skin | <input type="checkbox"/> Chest/Heart | <input type="checkbox"/> Recent changes in: |
| <input type="checkbox"/> Head/Neck | <input type="checkbox"/> Back | <input type="checkbox"/> Weight |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Intestinal | <input type="checkbox"/> Energy level |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Bladder | <input type="checkbox"/> Ability to sleep |
| <input type="checkbox"/> Throat | <input type="checkbox"/> Bowel | <input type="checkbox"/> Other pain/discomfort: |
| <input type="checkbox"/> Lungs | <input type="checkbox"/> Circulation | |
| Is there anything else about your health you would like me to know? | | |