**Health History Questionnaire**

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

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| **Basic Information** | |
| Patient Name: | Date of Birth: |
| Last Provider Seen/Date: | |
| Allergies/Reaction: | |

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| **Personal History** | | | | | |
| **Childhood**  **Illnesses** | **Dates**  ***(most recent)*** | **Immunizations** | **Dates**  ***(most recent)*** | **Health**  **Maintenance** | **Dates**  ***(most recent)*** |
| * Measles |  | * Tetanus |  | * Eye Exam |  |
| * Mumps |  | * Hepatitis |  | * EGD |  |
| * Rubella |  | * COVID |  | * EKG |  |
| * Chickenpox |  | * Flu |  | * Colonoscopy |  |
| * Rheumatic Fever |  | * H1N1 |  | * Bone Density Screening |  |
| * Polio |  | * Gardasil |  | * Cologuard |  |
| * Other |  | * Pneumonia |  | * Other |  |
| * Other |  | * Shingles |  | * Other |  |
| * Other |  | * PPD |  | * Other |  |

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| **Medical History** | | | | | | |  | **Females Only** |
| ***Please check box labeled C if the problem is Current and P in the problem occurred in the Past*** | | | | | | |  | Menstrual Flow:  🗆 Regular 🗆 Irregular 🗆 Pain/Cramps 🗆 Menopause  1st Day of your last period:  Sexually Active: Sexual Problems:  🗆 YES 🗆 NO 🗆 YES 🗆 NO  Birth Control Method:  # of Pregnancies: # of Miscarriages:  # of Live Births: # of Abortions:  🗆 Vaginal 🗆 C-Section  Date of Last Pap Smear:  🗆 Normal 🗆 Abnormal  Date of Last Mammogram:  🗆 Normal 🗆 Abnormal |
| **C** | **P** | **Respiratory / ENT** |  | **C** | **P** | **Cardiovascular** |  |
|  |  | Hearing Problems |  |  | High Blood Pressure |  |
|  |  | Ringing in Ears |  |  | Irregular Pulse |  |
|  |  | Prolonged Hoarseness |  |  | Fainting Spells |  |
|  |  | Sinus Trouble |  |  | Swollen Ankles |  |
|  |  | Vision Problems |  |  | Cold Numb Feet |  |
|  |  | Bronchitis |  |  | Varicose Veins |  |
|  |  | Chronic Cough |  |  | Dizzy Spells |  |
|  |  | Shortness of Breath |  |  | Leg Pain/Fatigue |  |
|  |  | Eye Pain |  |  | Chest Pain/Pressure |  |
|  |  | Nose Bleeds |  |  | Palpitations |  |
|  |  | Sore Throat |  |  | Heart Murmur |  |
|  |  | Pneumonia |  |  | Coronary Artery Disease |  |
|  |  | COPD/OSA | **C** | **P** | **Emotional** |  |
|  |  | Asthma |  |  | Depression |  |
|  |  | Wheezing |  |  | Mental Illness |  |
|  |  | **Gastrointestinal** |  |  | Mood Swings |  |
| **C** | **P** | Appetite |  |  | Thoughts of Death |  |
|  |  | Difficulty Swallowing |  |  | Sleep Problems |  |
|  |  | Bloody/Tar-Like Stool |  |  | Lack of Concentration |  |
|  |  | Hepatitis |  |  | Decreased Work Performance |  |
|  |  | Nausea/Vomiting |  |  | Anxiety |  |
|  |  | Bowel Changes |  |  | Bipolar |  |
|  |  | Abdominal Pain | **C** | **P** | **Urinary** |  | **Males Only** |
|  |  | Jaundice |  |  | >2 Overnight |  | Check all that apply  🗆 Vasectomy 🗆 Circumcision 🗆 Inguinal Hernia  Sexually Active: Sexual Problems:  🗆 YES 🗆 NO 🗆 YES 🗆 NO  Prostate Problems: Last PSA Date:  🗆 YES 🗆 NO |
|  |  | Crohn’s Disease |  |  | Stress Incontinence |  |
|  |  | Peptic Ulcer |  |  | Kidney Stone |  |
|  |  | Gallbladder |  |  | Blood in Urine |  |
|  |  | Constipation |  |  | Urinary Tract Infection |  |
|  |  | Diarrhea |  |  | Painful |  |
|  |  | Diverticulosis |  |  | Low Flow |  |
|  |  | Special Diet |  |  | Bed Wetting |  |

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| **Surgeries** |
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