Health History Questionnaire

Family Medicine Center

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NAME:_____

DATE OF BIRTH:_____

Please check all that apply:

PAST MEDICAL HISTORY:

☐ Chronic / Current conditions (Cancer, Heart, Kidney, Thyroid, Diabetes, High blood pressure, High cholesterol, Lung, Depression)

- ○ _____
- ○ _____
- ○ _____
- ○ _____
- ○ _____
- ○ _____

☐ Surgeries / Operations

- ○ Type / Year:_____
- ○ Type/ Year:_____
- ○ Type/ Year:_____

☐ Dietary History:

- ○ # of meals daily:_____
- ○ Snacks:_____
- ○ Vegetarian:_____
- ○ Fast food:_____
- ○ Other:_____
- ○ Weight at 19:_____
- ○ Current weight:_____

☐ Prior Tests / Year:

- ○ Mammogram:_____
- ○ Echocardiogram:_____
- ○ Chest X-Ray:_____
- ○ Stress test:_____
- ○ Colonoscopy:_____
- ○ Pap smear:_____
- ○ Bone density:_____
- ○ Sleep study:_____
- ○ Ultrasound / CT:_____
- ○ Other:_____

_____

☐ Hospitalizations:

- ○ Year:_____
- ○ Year:_____
- ○ Year:_____

☐ Recent ER visits:_____

_____

☐ Pregnancy:_____

IMMUNIZATIONS

- ☐ Pneumovax:_____
- ☐ Tdap:_____
- ☐ Flu (during season):_____
- ☐ Zoster (if over 60):_____
- ☐ Gardisil:_____
- ☐ TB test (PPD):_____
- ☐ Other:_____
- ☐ _____

ALLERGIES: None known or list:

- ○ _____
- ○ _____
- ○ _____
- ○ _____
- ○ _____

SOCIAL AND PERSONAL HISTORY

☐ Tobacco use? Y or N

Cigarettes (_____per day for _____ years)

Chewing? Y or N

E-cigarretes Y or N

Second-hand smoke? Y or N

☐ Alcohol: Social or Daily

Beer:_____

Wine:_____

Mixed drinks:_____

☐ Caffeine: Y or N

per day

Soda:_____

Coffee:_____

Tea:_____

Chocolate:_____

☐ Exercise

Aerobic:_____ # hours/week

Strength:_____ # hours/week

Stretch: _____ # hours/week

☐ Illegal drugs:_____

☐ Highest education:_____

☐ Travel outside USA:_____

☐ Marital Status: Single / Married / Widowed Separated / Divorced

☐ Partner / Spouse name:_____

☐ Number of children:_____

☐ Occupation:_____

☐ Hobbies / Interests:_____

☐ Driving concerns:_____

☐ Do you wear seatbelts?_____

☐ Talk on mobile or text while driving?

_____

DISABILITY:

☐ Mental:_____

☐ Physical:_____

FAMILY MEMBER WITH:

- ☐ Cancer:_____
- ☐ Heart disease:_____
- ☐ Early deaths:_____
- ☐ Genetic disease:_____
- ☐ Hyptertension:_____
- ☐ Thyroid:_____
- ☐ Diabetes:_____
- ☐ High Cholesterol:_____
- ☐ Alcoholism:_____
- ☐ Osteoporosis:_____
- ☐ Other:_____

PLEASE TURN OVER PAGE

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DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS:

CONSTITUTIONAL:

- ☐ Fever
- ☐ General pain
- ☐ Unexplained weight loss or gain
- ☐ Chills
- ☐ Fatigue

HEAD RELATED:

- ☐ Headache
- ☐ Sinus Pain

EYE SYMPTOMS:

- ☐ Eyesight problems
- ☐ Foreign body sensation
- ☐ Dry eyes
- ☐ Pus drainage
- ☐ Cataract
- ☐ Glaucoma

EAR NOSE AND THROAT SYMPTOMS:

- ☐ Ear
- ☐ Nose
- ☐ Throat
- ☐ Throat pain

NECK SYMPTOMS:

- ☐ Stiffness
- ☐ Swollen glands

CARDIOVASCULAR SYMPTOMS:

- ☐ Palpitations (fast heart beat)
- ☐ Chest pain or discomfort

GASTROINTESTINAL:

- ☐ Abdominal pain
- ☐ Blood in stool
- ☐ Black or tarry stool
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Swelling / bloating
- ☐ Constipation
- ☐ Change in appetite
- ☐ Heartburn

GENITOURINARY:

- ☐ Dysuria (painful urination)
- ☐ Polyuria (increased urination)
- ☐ Urinary incontinence
- ☐ Nocturia (getting up at night to urinate)
- ☐ (Men) Erectile problems
- ☐ Other:

SKIN:

- ☐ Lesions
- ☐ Nails

BREAST:

- ☐ Nipple discharge
- ☐ Warmth
- ☐ Lumps

MUSCOSKELETAL SYMPTONS:

- ☐ _____

NEUROLOGICAL SYMPTOMS:

- ☐ Dizziness
- ☐ Memory lapses or loss
- ☐ Sensory disturbances
- ☐ Poor coordination
- ☐ Frequently becoming lost
- ☐ Frequent questions about recent events
- ☐ Frequent falls while walking
- ☐ Spinning dizziness (vertigo)

PULMONARY:

- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath

PSYCHOLOGICAL SYMPTOMS:

- ☐ Depression
- ☐ Anxiety
- ☐ Sleep problems, snoring, apnea

HEMATOLOGIC SYMPTOMS:

- ☐ Bruise easily
- ☐ Anemia

ENDOCRINE:

- ☐ Temperature intolerance
- ☐ Hot flashes
- ☐ Excessive hair loss
- ☐ Change in libido (sex drive)
- ☐ Women only:
  - Age at onset of menses: _____
  - Last period: _____
  - Age at onset of menopause: _____

CURRENT MEDICATIONS

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

CURRENT VITAMINS / SUPPLEMENTS/ OTC PRODUCTS / HERBAL MEDICATIONS

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

OTHER PHYSICIANS / PROVIDERS THAT YOU SEE

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

WHAT HEALTH SCREENING DOES *NOT* PAY FOR:

If problems are identified during this screening procedure (in other words a problem that requires further tresting or a prescription) this will be billed at an appropriate additional rate. Simple problems will incur a Level II charge. Complex and multiple problems a Level III, Level IV or Level V charge. For example, if prescriptions are written for blood pressure, diabetes, and cholesterol medication and you need an X-Ray for back pain you will be billed an office visit for Level IV in addition to the charge for screening that will be paid for by the insurance company. If you have knee pain or sinusitis and you want this addressed during your health screening, that would be an additional Level III charge. You will be responsible for any additional charges on the date of service, unless you choose to have the additional issue(s) treated on a subsequent visit.

SIGNATURE: _____

DATE: _____