

Date:

*HealthCare for Business*

**HEALTH HISTORY QUESTIONNAIRE**

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name (Last, First, M.I.):	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
---------------------------	---	------

SOCIAL HISTORY	
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 minutes) <input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation, 4x/week for 30 minutes)
Diet	Are you dieting? <span style="float: right;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</span> If yes, are you on a physician prescribed medical diet? <span style="float: right;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</span> Rank salt intake: <span style="float: right;"><input type="checkbox"/> HIGH   <input type="checkbox"/> MEDIUM   <input type="checkbox"/> LOW</span> Rank fat intake: <span style="float: right;"><input type="checkbox"/> HIGH   <input type="checkbox"/> MEDIUM   <input type="checkbox"/> LOW</span>
Caffeine	Rank caffeine intake: <span style="float: right;"><input type="checkbox"/> HIGH   <input type="checkbox"/> MEDIUM   <input type="checkbox"/> LOW</span>
Alcohol	Do you drink alcohol? <span style="float: right;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</span> If yes, what kind and how much per week? Are you concerned about the amount you drink? <span style="float: right;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</span> Have you considered stopping? <span style="float: right;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</span> Have you ever experienced blackouts? <span style="float: right;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</span> Are you prone to "binge" drink? <span style="float: right;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</span> Do you drive after drinking? <span style="float: right;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</span>
Tobacco	Do you use tobacco? <span style="float: right;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</span> <input type="checkbox"/> Cigarettes ____ pks./day <input type="checkbox"/> Chew - #/day <input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day For how many years? _____ (or) year quit? _____
Drugs	Do you currently use recreational or street drugs? <span style="float: right;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</span> Have you ever given yourself street drugs with a needle? <span style="float: right;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</span>
Sex	Are you sexually active? <span style="float: right;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</span> If yes, are you trying for a pregnancy? <span style="float: right;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</span> If not trying for a pregnancy, list contraceptive method used: Any discomfort with intercourse? <span style="float: right;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</span>
Personal Safety	Do you live alone? <span style="float: right;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</span> Do you have frequent falls? <span style="float: right;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</span> Do you have vision or hearing loss? <span style="float: right;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</span> Do you have an Advance Directive or Living Will? <span style="float: right;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</span>
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
Employment	Place of Employment: Hours per week: Normal Shift: <input type="checkbox"/> Day <input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> Rotating Are you here for a work related injury? <span style="float: right;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</span> Injury Report completed? <span style="float: right;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</span> Date of injury: _____

**PAST MEDICAL HISTORY**

Date of last physical exam:

Childhood illness:  Measles     Mumps     Rubella     Chickenpox     Rheumatic Fever     Polio

Immunizations and dates:

<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR (Measles, Mumps, Rubella)

**Surgeries**

Year	Reason	Hospital

**Other hospitalizations**

Year	Reason	Hospital

- Have you ever had a blood transfusion?  YES     NO
- Is stress a major problem for you?  YES     NO
- Do you feel depressed?  YES     NO
- Do you panic when stressed?  YES     NO
- Do you have problems with eating or your appetite?  YES     NO
- Do you cry frequently?  YES     NO
- Have you ever attempted suicide?  YES     NO
- Have you ever seriously thought about hurting yourself?  YES     NO
- Do you have trouble sleeping?  YES     NO
- Have you ever been to a counselor?  YES     NO

**FAMILY HEALTH HISTORY**

Significant Health Problems		Children	Significant Health Problems	
<b>Father</b>			<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Mother</b>		<input type="checkbox"/> M <input type="checkbox"/> F		
<b>Siblings</b>	<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	<b>Grandmother (Maternal)</b>		
	<input type="checkbox"/> M <input type="checkbox"/> F	<b>Grandfather (Maternal)</b>		
	<input type="checkbox"/> M <input type="checkbox"/> F	<b>Grandmother (Paternal)</b>		
	<input type="checkbox"/> M <input type="checkbox"/> F	<b>Grandfather (Paternal)</b>		

**REFERRED BY**

- Physician \_\_\_\_\_     Attorney \_\_\_\_\_     Friend or Family Member  
 I am a previous patient     Yellow Pages     Advertisement     Other

### ROUTINE MEDICATIONS

List your prescribed drugs and over-the counter drugs, such as vitamins and inhalers

Name of drug	Strength	Frequency Taken

### ALLERGIES

Name of Drug/Substance	Reaction

### PROBLEM LIST

List any medical problems that other doctors have diagnosed:


#### Women Only

Age of onset of menstruation: \_\_\_\_\_

Date of last menstruation: \_\_\_\_\_

Period every \_\_\_\_\_ days

Heavy periods, irregularity, spotting, pain, or discharge?  YES  NO

Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_

Are you pregnant or breastfeeding?  YES  NO

Have you had a D&C, hysterectomy, or Cesarean?  YES  NO

Any urinary tract, bladder, or kidney infections within the last year?  YES  NO

Any blood in your urine?  YES  NO

Any problems with control of urination?  YES  NO

Any hot flashes or sweating at night?  YES  NO

Do you have menstrual tension, pain, bloating or irritability around time of period?  YES  NO

Experienced any recent breast tenderness, lumps, or nipple discharge?  YES  NO

Date of last pap and rectal exam: \_\_\_\_\_

#### Men Only

Do you usually get up to urinate during the night?  YES  NO

If yes, # of times \_\_\_\_\_

Do you feel pain or burning with urination?  YES  NO

Any blood in your urine?  YES  NO

Do you feel burning discharge from penis?  YES  NO

Has the force of your urination decreased?  YES  NO

Have you had any kidney, bladder, or prostate infections within the last 12 months?  YES  NO

Do you have any problems emptying your bladder completely?  YES  NO

Any difficulty with erection or ejaculation?  YES  NO

Any testicle pain or swelling?  YES  NO

Date of last prostate and rectal exam: \_\_\_\_\_