The Center for Family Medicine, Wellness & Aesthetics

Health History Questionnaire

Today's Date_____

Last Name_____ First Name_____ M.I.___ Date of Birth_____
Birthplace_____ Sex: M / F Education/Degrees_____ Occupation_____
Single_____ Married_____ Committed relationship____ Separated_____ Divorced Widowed__

MEDICAL HISTORY (Please check conditions you have now, or have had in the past.)

□ Heart Disease	□ Cancer	□ Rheumatic Fever	□ Anemia
□ Stroke	□ Breast Lump	□ Tuberculosis	□ Bleeding Disorder
□ Diabetes	□ Prostate Problem	□ Hepatitis	□ Thyroid Problem
□ High Blood Pressure	□ Cataracts	□ Herpes	□ Kidney Disease
□ High Cholesterol	□ Glaucoma	□ Venereal Disease	□ Liver Disease
□ Asthma	□ Migraine Headaches	□ HIV/AIDS	□ Anxiety/depression
□ Emphysema	□ Epilepsy	□ Arthritis	□ Alcohol/drug Abuse

HOSPITALIZATIONS (List all, for illness or surgery, beginning with the most recent.)

Date	**Reason**	**Hospital**	**Physician**

MEDICATIONS, VITAMINS, SUPPLEMENTS

Our staff will enter your prescription medications into our electronic medical record, so please have that information ready. Circle the following, which are available without a prescription, that you use:

Laxatives Antacids Aspirin Ibuprofen or Naproxen
Decongestants Allergy Pills Nasal Sprays Other
Vitamins Herbs Supplements Natural Hormones

ALLERGIES (If you are allergic to any of the following, please describe the reaction you had.)
Penicillin_____ Sulfa _____ Other_____

PREVENTIVE SERVICES (List the date you last had these preventive medicine services or tests.)
Physical examination:_____ Physician:_____
Heart Disease Prevention:
High cholesterol: Lipid profile_____ hsCRP_____
Cancer Screening:
Breast cancer: Mammogram_____
Cervical cancer: PAP smear_____
Colon cancer: Colonoscopy_____ or stool test _____and flexible sigmoidoscopy_____
Prostate cancer: PSA (prostate specific antigen)_____
Infectious Disease Prevention: (List year of most recent immunization)
MMR_____ Tetanus_____ Hepatitis B_____ Hepatitis A_____
Flu_____ Pneumonia_____
Metabolic Disorder Screening:
Osteoporosis: DEXA Scan (bone density test)_____

LIFESTYLES AFFECTING HEALTH (Please answer these questions.)
Weight: Now _____1 year ago_____ Desired_____
Habits: Use seat belts 80-100% _____50-80%_____ Less than 50%_____
Tobacco: Never_____ Age started_____ Age stopped_____
Cigarettes_____(packs/day) Cigars___ Pipe_____Snuff____ Chewing tobacco_____-
Alcohol: Never_____ 0-6 drinks/week _____7-14 drinks/week____ Over 14/week____
Special diet? Type:_____
Exercise: Type:_____ Frequency, distance or amount:_____
Women: Do you do regular breast self-exam? □ Yes □ No
Men: Do you do regular testicular self-exam? □ Yes □ No

Patients Name: _____

MENSTRAL HISTORY

Age at onset_____ Date of last period_____ Cycle (from start to start)_____ days
Usual duration of flow_____days Flow is: Heavy___ Medium___ Light___ Pain or cramp?___
Periods irregular?_____ Have had vaginal infections or frequent discharge?_____
Taking birth control pills?_____ Have an IUD?_____ Have had abnormal PAP?_____
Pregnancies Total number_____ How many children born alive?_____

Family History	If Living		If Deceased				
	Age	Health	Age at Death	Cause	Check if any parent or sibling ever had:	Check if Yes	Relationship
Father					Allergies		
					Asthma		
Mother					Arthritis		
					Glaucoma		
1.Brother/Sister					Cancer-What kind?		
					Tuberculosis		
2.Brother/Sister					Diabetes		
					Heart Trouble		
3.Brother/Sister					High Blood Pressure		
					Stroke		
4.Brother/Sister					High Cholesterol		
					Stomach Ulcers		
Spouse					Epilepsy/Seisures		
					Substance Abuse		
1.Son/Daughter					Anxiety		
					Depression		
2.Son/Daughter					Suicide		
					Kidney Trouble		
3.Son/Daughter					Birth Defects		
					Sickle Cell Anemia		
4.Son/Daughter					Mental Retardation		

Who lives at home with you? _____

Patients Name:_____

REVIEW OF SYSTEMS: Check (√) any symptoms you have had in the past 6 months

General:

YES

- □ Fevers
- □ Chills
- □ Sweats
- □ Loss of appetite
- □ Fatigue
- □ Weakness
- □ Malaise
- □ Weight loss
- □ Sleep Disorder

Eyes:

YES

- □ Blurring
- □ Double vision
- □ Irritation
- □ Discharge
- □ Vision loss
- □ Eye pain
- □ Eye pain in light

Ears/Nose/Throat

YES

- □ Earache
- □ Ear discharge
- □ Decreased hearing
- □ Nasal congestion
- □ Nosebleeds
- □ Sore throat
- □ Hoarseness
- □ Difficulty swallowing

Cardiovascular

YES

- □ Chest Pain
- □ Fainting
- □ Shortness of breath walking
- □ Shortness of breath laying flat
- □ Shortness of breath at night
- □ Leg swelling

Respiratory

YES

- □ Cough
- □ Shortness of breath
- □ Excessive sputum
- □ Coughing up blood
- □ Wheezing
- □ Pleurisy

Gastrointestinal

YES

- □ Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Change in bowel habits
- □ Abdominal pain
- □ Black Stool
- □ Bloody Stool
- □ Jaundice
- □ Gas/Bloating
- □ Indigestion/heartburn
- □ Pain with swallowing

Female Genitourinary

YES

- □ Vaginal discharge
- □ Incontinence
- □ Pain with Urination
- □ Blood in urine
- □ Get up at night to urinate
- □ Urinary frequency
- □ Missed your period
- □ Heavy Period
- □ Abnormal vaginal bleeding
- □ Pelvic pain
- □ Genital sores
- □ Painful intercourse
- □ Decreased sexual drive

Male Genitourinary

YES

- □ Pain with Urination
- □ Blood in urine
- □ Discharge
- □ Urinary frequency
- □ Urinary hesitancy
- □ Get up at night to urinate
- □ Incontinence
- □ Genital sores
- □ Decreased Libido
- □ Erectile dysfunction

Musculoskeletal

YES

- □ Back pain
- □ Joint pain
- □ Joint swelling
- □ Muscle cramps
- □ Muscle weakness
- □ Stiffness
- □ Arthritis
- □ Sciatica
- □ Restless legs
- □ Leg pain at night
- □ Leg pain with exercise

Skin

YES

- □ Rash
- □ Itching
- □ Dryness
- □ Suspicious lesions

Neurological

YES

- □ Paralysis
- □ Numbness
- □ Seizures
- □ Tremors
- □ Vertigo
- □ Loss of vision
- □ Frequent falls
- □ Frequent headaches
- □ Difficulty walking
- □ Weakness
- □ Fainting
- □ Headache

Mental

YES

- □ Depression
- □ Anxiety
- □ Memory loss
- □ Suicidal thoughts
- □ Hallucinations
- □ Paranoia
- □ Phobia
- □ Confusion

Endocrine

YES

- □ Cold intolerance
- □ Heat intolerance
- □ Increased Thirst
- □ Eating more
- □ Urinating more
- □ Weight change

Heme/Lymphatic

YES

- □ Abnormal bruising
- □ Bleeding
- □ Enlarged lymph nodes

Allergic/Immunologic

YES

- □ Hives
- □ Allergic rash
- □ Sneezing
- □ Hay fever
- □ Recurrent infections
- □ HIV exposure