**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.): M F  | **DOB:**  |
| **Marital status:**  Single Partnered Married Separated Divorced Widowed  |
| **Education level / background:**  | **Occupation (pre-retirement):** |
| **Previous or referring doctor:**  | **Date of last physical exam:**  |

**PERSONAL HEALTH HISTORY**



**Prescription drugs and over-the-counter drugs, vitamins, and inhalers**

|  |  |  |
| --- | --- | --- |
| Name the Drug  | Strength  | Frequency Taken  |
|  |  |  |
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| **Allergies to medications**  |  |
| Name the Drug  | Reaction You Had  |  |
|  |  |
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|  |  |

**HEALTH HABITS AND PERSONAL SAFETY**





**FAMILY HEALTH HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | AGE  | SIGNIFICANT HEALTH PROBLEMS  | AGE  | SIGNIFICANT HEALTH PROBLEMS  |
| **Father**  |  |  | **Children**  |  |  |  M  F  |  |
|  |
| **Mother**  |  |  |  |  |  M  F  |  |
|  |
| **Sibling**  |  |  |  M  F  |  |  |  |  M  F  |  |
|  |  |
|  |  |  M  F  |  |  |  |  M  F  |  |
|  |  |
|  |  |  M  F  |  | **Grandmother** Maternal  |  |  |
|  |
|  |  |  M  F  |  | **Grandfather** Maternal  |  |  |
|  |
|  |  |  M F  |  | **Grandmother** Paternal  |  |  |
|  |
|  |  |  M  F  |  | **Grandfather** Paternal  |  |  |
|  |

**MENTAL HEALTH**

|  |  |  |
| --- | --- | --- |
| 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  |

**WOMEN ONLYMEN ONLYOTHER PROBLEMS**

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

|  |  |  |
| --- | --- | --- |
|  **Skin**  |  **Chest/Heart**  |  **Recent changes in:**  |
|  **Head/Neck**  |  **Back**  |  **Weight**  |
|  **Ears**  |  **Intestinal**  |  **Energy level**  |
|  **Nose**  |  **Bladder**  |  **Ability to sleep**  |
|  **Throat**  |  **Bowel**  |  **Other pain/discomfort:**  |
|  **Lungs**  |  **Circulation**  |  |