**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**

A picture containing timeline

Description automatically generated

**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 |  |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |

**HEALTH HABITS AND PERSONAL SAFETY**

Timeline

Description automatically generated with medium confidence

Background pattern

Description automatically generated

**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 ONLYBackground pattern

Description automatically generated with low confidenceMEN ONLYBackground pattern

Description automatically generatedOTHER 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** |  |