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| **Center for adult and pediatric wellness** | | | | | | | | | | | | |
| **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 🞎Transgender | | **DOB:** |  | | | |
| **Sexual Orientation:** | | 🞎 Heterosexual 🞎 Lesbian/Gay 🞎 Bisexual 🞎 Other | | | |  | | **Religion:** | | | | |
| **Marital status: 🞎 Single 🞎 Partnered 🞎 Married 🞎 Separated 🞎 Divorced 🞎 Widowed** | | | | | | | | | | | | |
| **Education level: 🞎 Grade School 🞎 Middle School 🞎 High School 🞎 College 🞎 Graduate School 🞎 Degree\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | |
| **Occupation:** | | | | | |  | | | | | | |
| **Do you every have to choose between food, utilities and/or medications?** | | | | | |  | | | | | | |
| **Who lives with you at home? (ie Mother, Son)** | | | | | |  | | | | | | |
| **Do you rely on other people to get you to work/school/doctor’s appointments?** | | | | | |  | | | | | | |
| **Are you comfortable being outdoors in your neighborhood? (Going for walks)** | | | | | |  | | | | | | |
| **Previous or referring doctor:** | | | |  | | **Date of last physical exam:** | | |  | | | |
|  | | | | | | | | | | | | |
| PERSONAL HEALTH HISTORY | | | | | | | | | | | | |
| **Past Childhood Illnesses - Were you DIAGNOSED with any of the following illnesses?** | | | | | | | | | | | | |
| 🞎 Measles 🞎 Mumps 🞎 Rubella 🞎 Chickenpox 🞎 Rheumatic Fever 🞎 Polio 🞎 None of the following | | | | | | | | | | | | |
| **IMMUNIZATION History:**   |  |  | | --- | --- | | 🞎 Tetanus Date: | 🞎 Meningococcal Date: | | 🞎 Tdap Date: | 🞎 Pneumonia Date: | | 🞎 Hepatitis A Date: | 🞎 Shingles Date: | | 🞎 Hepatitis B Date: | 🞎 Chickenpox Date: | | 🞎 Influenza Date: | 🞎 MMR Measles, Mumps, Rubella Date: | | | | | | | | | | | | | |
| 🞎 Tetanus Date: | | | | | 🞎 Meningococcal Date: | | | | | | | |
| 🞎 Tdap Date: | | | | | 🞎 Pneumonia Date: | | | | | | | |
| 🞎 Hepatitis A Date: | | | | | 🞎 Shingles Date: | | | | | | | |
| 🞎 Hepatitis B Date: | | | | | 🞎 Chickenpox Date: | | | | | | | |
| 🞎 Influenza Date: | | | | | 🞎 MMR Measles, Mumps, Rubella Date: | | | | | | | |
| **Do you see a Dentist at least once a year?** | | | | | | | | | | | | |
| **List any medical problems that other doctors have diagnosed** | | | | | | | | | | | | |
| * Hypertension | | | |  | | * Prediabetes | | |  | | | |
| * High Cholesterol | | | |  | | * GERD | | |  | | | |
| * Hypothyroidism (low thyroid) | | | |  | | * Depression | | |  | | | |
| * Hyperthyroidism (high thyroid) | | | |  | | * Anxiety | | |  | | | |
| * COPD | | | |  | | * Heart Problems - | | |  | | | |
| * Emphysema | | | |  | | * Cancer - | | |  | | | |
| * Asthma | | | |  | | * Other(s): | | |  | | | |
| * Diabetes * Circle One: Type 1 OR Type 2 | | | |  | |  | | |  | | | |
| **Surgeries** | | | | | | | | | | | | |
| Year | | | Reason | | | | | Hospital | | | | |
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| **Other hospitalizations** | | | | | | | | | | | | |
| Year | | | Reason | | | | | Hospital | | | | |
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| **Have you ever had a blood transfusion?** | | | | | | | | | 🞎 | Yes | 🞎 | No |
| **PERSONAL HEALTH HISTORY CONT.** | | | | | | | | | | | | |
| **List your prescribed drugs and over-the-counter drugs, such as 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** | | | | | | | | | | | | |
| All questions contained in this questionnaire are optional and will be kept strictly confidential. | | | | | | | | | | | | |
| **Exercise** | 🞎 Sedentary (No exercise) | | | | | | | | | | | |
| 🞎 Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | | | | | | | | | | |
| 🞎 Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) | | | | | | | | | | | |
| 🞎 Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) | | | | | | | | | | | |
| **Diet** | Are you dieting? | | | | | | | | 🞎 | Yes | 🞎 | No |
| If yes, are you on a physician prescribed medical diet? | | | | | | | | 🞎 | Yes | 🞎 | No |
| # of meals you eat in an average day? | | | | | | | | | | | |
| Rank salt intake | | | 🞎 Hi | | 🞎 Med | 🞎 Low | | | | | |
| Rank fat intake | | | 🞎 Hi | | 🞎 Med | 🞎 Low | | | | | |
| **Caffeine** | 🞎 None | | | 🞎 Coffee | | 🞎 Tea | 🞎 Cola | | | | | |
| # of cups/cans per day? | | | | | | | | | | | |
| **Alcohol** | Do you drink alcohol? | | | | | | | | 🞎 | Yes | 🞎 | No |
| If yes, what kind? | | | | | | | | | | | |
| How many drinks per week? | | | | | | | | | | | |
| Are you concerned about the amount you drink? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Have you considered stopping? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Have you ever experienced blackouts? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Are you prone to “binge” drinking? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Do you drive after drinking? | | | | | | | | 🞎 | Yes | 🞎 | No |
|  | Does anyone in your family drink Alcohol? | | | | | | | | 🞎 | Yes | 🞎 | No |

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| **HEALTH HABITS AND PERSONAL SAFETY CONT.** | | | | | | | | | | | | | |
| **Tobacco** | | Do you use tobacco? | | | | | | | | 🞎 | Yes | 🞎 | No |
| 🞎 Cigarettes – pks./day | | | 🞎 Chew - #/day | | 🞎 Pipe - #/day | | 🞎 Cigars - #/day | | | | |
| 🞎 # of years |  | | | | | | | | | | |
|  | Former smoker? | | | 🞎 Yes | | 🞎 No | | 🞎 If yes, specify the year you quit: | | | | | |
|  | Does Anyone in your household smoke? Are you exposed to secondhand smoking? | | | | | | | | | | | | |
|  | | Do you currently use recreational or street drugs? | | | | | | | | 🞎 | Yes | 🞎 | No |
| **Drugs** | | Does anyone in your family use recreational or street drugs? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Have you ever given yourself street drugs with a needle? | | | | | | | | 🞎 | Yes | 🞎 | No |
| **Sex** | | Are you sexually active? | | | | | | | | 🞎 | Yes | 🞎 | No |
| If yes, are you trying for a pregnancy? | | | | | | | | 🞎 | Yes | 🞎 | No |
| If not trying for a pregnancy list contraceptive or barrier method used: | | | | | | | | | | | |
| Any discomfort with intercourse? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Are you involved in risky sexual behaviors? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? | | | | | | | |  |  |  |  |
| 🞎 | Yes | 🞎 | No |
| **Personal Safety** | | Do you live alone? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Do you have frequent falls? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Do you have vision or hearing loss? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Do you have an Advance Directive or Living Will? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Would you like information on the preparation of these? | | | | | | | | 🞎 | Yes | 🞎 | No |
| Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? | | | | | | | |  |  |  |  |
| 🞎 | Yes | 🞎 | No |

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| **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* |  | |  |

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| **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 |
| Do you feel anxious in social settings? | 🞎 | Yes | 🞎 | No |
| Have you ever been to a counselor? | 🞎 | Yes | 🞎 | No |
| Family History of mental illness? | 🞎 | Yes | 🞎 | No |

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| **WOMEN ONLY** | | | | |
| Age at 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, irritability, or other symptoms at or 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? | 🞎 | Yes | 🞎 | No |

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| **OTHER 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 |  |  |