Health History Questionnaire

Today's Date _____

Patient Name _____

Birthdate _____ **Age** _____

Gender _____

Westside Provider _____

Previous Primary Care Provider _____

When were you last seen by a physician (or Emergency Room)? _____**Why?** _____

Doctor's name _____ **Area of Specialty** _____

LIST THE REASON(S) FOR YOUR VISIT TODAY: _____ **LIST ANY ALLERGIES:**

	What are you allergic to?
Medications	
Food	
Latex	YES ☐ NO ☐

LIST THE MEDICATIONS THAT YOU TAKE: **LIST SPECIALIST(S) YOU SEE AND WHY:**

Specialist Name	Medical Reason

REVIEW OF SYSTEMS **Place a checkmark in the box next to any symptoms you are having today**

☐ weight loss	☐ dry skin	☐ wheezing	☐ nausea	☐ joint stiffness
☐ weight gain	☐ vision changes	☐ difficulty breathing with exercise	☐ vomiting	☐ joint swelling
☐ fatigue	☐ blurred vision		☐ diarrhea	☐ headache
☐ insomnia	☐ runny nose	☐ breast mass/lump	☐ constipation	☐ balance problem
☐ weakness	☐ nasal congestion	☐ nipple discharge	☐ blood in stool	☐ memory loss
☐ fever	☐ hearing loss	☐ chest pain	☐ black tarry stool	☐ depression
☐ frequent infections	☐ ringing in ears	☐ shortness of breath	☐ incontinence	☐ anxiety
☐ swollen lymph nodes	☐ ear problems	☐ irregular heart beat	☐ painful urination	☐ panic attacks
☐ rash	☐ dental problems	☐ swelling of extremities	☐ nighttime urinating	☐ mood changes
☐ hives	☐ mouth sores/ulcers	☐ fainting/passing out	☐ frequent urinating	☐ heat intolerance
☐ new skin lesion	☐ sore throat	☐ abdominal pain	☐ changed urine stream	☐ cold intolerance
☐ changes in mole	☐ cough	☐ indigestion/heartburn	☐ joint pain	☐ bruising/bleeding

IMMUNIZATIONS **List the last year you had any of the following:**

Tetanus _____ Hep B _____ MMR _____ Pneumonia _____ Flu _____ PPD _____ HPV _____

HOSPITALIZATION, SURGICAL, INJURY HISTORY None ☐ or **List below the type and year it occurred**:

Reason for Hospitalization_____

Surgery_____

Injury_____

DO NOT SCAN

MEDICAL HISTORY **Please check the box if you and/or family members have had any of the following conditions**.

Medical Condition	You	Family Member		Medical Condition	You	Family Member
Heart Attack	☐	☐		Seizures	☐	☐
Heart Failure	☐	☐		Thyroid Disease	☐	☐
High Blood Pressure	☐	☐		Diabetes	☐	☐
High Cholesterol	☐	☐		Dialysis	☐	☐
Stroke	☐	☐		Hepatitis	☐	☐
Heart Murmur	☐	☐		Cirrhosis	☐	☐
Blood clots	☐	☐		Stomach ulcers	☐	☐
Anemia	☐	☐		Colon polyps	☐	☐
Asthma	☐	☐		Glaucoma	☐	☐
Allergies	☐	☐		Cataracts	☐	☐
Eczema	☐	☐		Cancer	☐	☐
COPD	☐	☐		Mental Illness	☐	☐
Arthritis	☐	☐		Alcoholism	☐	☐
Gout	☐	☐		Tuberculosis	☐	☐
Other:_____				Other:_____		

PREVENTIVE HEALTH **Put the date and results of the last year in which you had any of the following:**

WOMEN & MEN	Year	Results	
		Normal	Abnormal
Physical Exam		☐	☐
Dental Exam		☐	☐
Colonoscopy		☐	☐
HIV Test		☐	☐
STD Screen		☐	☐

WOMEN	Year	Results	
		Normal	Abnormal
PAP Screening		☐	☐
Mammogram		☐	☐
MEN			
PSA		☐	☐
Prostate Exam		☐	☐

REPRODUCTIVE HEALTH

Women: Last Menstrual Period_____ Number of Pregnancies_____ Number of Births _____

Women and Men:

Are you sexually active? Yes ☐ No ☐ Partner(s): Men ☐ Women ☐ Both ☐

Birth control: Condom ☐ Vasectomy ☐ Pill ☐ Patch ☐ DEPO ☐ IUD ☐ Implanon/Nexplanon ☐ Tubal Ligation ☐

HOME LIFE/LIFESTYLE/SOCIAL

Who lives with you? Partner: Yes ☐ No ☐ Parents: Yes ☐ No ☐ # Children: _____

Others:_____

What is your marital status? Married ☐ Civil Union ☐ Single ☐ Divorced ☐ Widow/Widower ☐

Are you employed? Yes ☐ No ☐ If yes, Fulltime ☐ Part-time ☐

Occupation?_____

What is your education level? Below High School ☐ High School Graduate ☐ College Graduate ☐ Advanced degree ☐

Do you wear a seat belt? Yes ☐ No ☐

Do you ever wear a helmet? Yes ☐ No ☐ If yes, for what activity? _____

Do you have guns in your house? Yes ☐ No ☐ Do you have smoke alarms in your house? Yes ☐ No ☐

Do you exercise Daily ☐ Weekly ☐ Monthly ☐ None ☐

How many times a day do you eat Fruits/vegetables _____ Meat/beans _____ Dairy _____ Junk food/Sodas _____

Do you drink alcohol? Yes ☐ No ☐ If yes, how much?_____

Do you use/smoke tobacco? Yes ☐ No ☐ If yes, how much?_____

Do you use illegal drugs or a prescription medication for non-medical reasons? Yes ☐ No ☐