Health Questionnaire

Patient Name:_____ Preferred Name:_____

Preferred Pronouns: ☐ She/Her ☐ He/Him ☐ Them/They ☐ Other _____

Date of Birth:_____ Today's Date:_____

Primary Care Provider:_____

Reason for today's visit: _____

Year of Last		Year of Last	
Total Physical		Bone Scan (DEXA)	
Pap Smear		HPV Vaccine	
Mammogram		Flu Vaccine	
Colonoscopy			

Please list all medications you are currently taking. Include vitamins, supplements and medications including prescriptions, inhalers, and over-the-counter drugs.

Drug Name	Strength	Frequency Taken
1.		
2.		
3.		
4.		
5.		

Please check to indicate if you have ever had the following conditions:

☐ Anxiety Disorder	☐ Emphysema	☐ Obesity
☐ Arthritis	☐ Eye Problems Type_____	☐ Pulmonary Embolism
☐ Asthma	☐ Fibromyalgia	☐ Reflux or ☐ Ulcers
☐ Allergies or Hay fever	☐ Gout	☐ Seizures
☐ Anemia or ☐Blood Transfusion	☐ Headaches or ☐ Migraines	☐ Sexually Transmitted Infections
☐ Bleeding Disorder	☐ Heart Attack	☐ Skin Disease or Chronic Rashes
☐ Blood Clots/DVT	☐ Heart Murmur	☐ Stroke
☐ Cardiac Arrhythmia or Pacemaker	☐ HIV or AIDs	☐ Substance Use Disorder
☐ Congestive Heart Failure	☐ High Cholesterol	☐ Thyroid Disease
☐ Coronary Artery Disease	☐ High Blood Pressure	☐ Tuberculosis
☐ Depression	☐ Insomnia	☐ Unhealthy Alcohol Use
☐ Diabetes	☐ Kidney Disease	☐ Cancer Type _____
☐ Dialysis	☐ Kidney Stones	
☐ Diverticulitis	☐ Liver Disease or Hepatitis	☐ Other Please Explain_____
☐ Eating Disorder	☐ Osteoporosis	

List Medication Allergies or Reactions: **If no allergies check ☐ NONE**

Medication Allergy	Reaction
1.	
2.	
3.	

Please list any surgeries or overnight hospital stays:

Type of surgery/reason for hospitalization	Reason	Date or Approx Year
1.		
2.		
3.		

Women's Health

Menstrual Flow: □ Monthly □ Irregular □ Pain/Cramps □ absent Since_____
First Day of Last Period: _____ Days of Flow: _____ Number of Days between Menses: _____
Pregnancies: _____ Miscarriages: _____ Induced Abortions: _____ Living Children: _____

Any History of Abnormal Pap Smears? □ Yes □ No
If yes, what type? □ ASCUS, Atypical squamous cells of undetermined significance □ LSIL, Low-grade squamous intraepithelial lesion □ HSIL, High-grade squamous intraepithelial lesion □ HPV Positive □ Unsure
What Year? _____

Social History

Do you smoke or use any tobacco products?
☐ Yes ☐ No ☐ Quit
Number of cigarettes each day? ____ For how many years? _____Other forms of tobacco used? _____

Do you use marijuana? ☐ Yes ☐ No ☐ Quit
How much? _____ How often? _____

Do you regularly use other drugs?
☐ Yes ☐ No ☐ Quit
Type of other drugs used _____

Exercise Routine: _____

Dietary Restrictions/Concerns: _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit
If yes, please complete the following:

Any history of Domestic Violence? □ Yes □ No
Any history of Sexual Abuse? □ Yes □ No
Do you feel safe at home? □ Yes □ No
Are you Sexually Active? □ Yes □ No
If yes, with: □ Men □ Women □ Both
Do you want STD testing today? □ Yes □ No

Current Pregnancy Prevention
□ IUD
□ Oral Birth Control
□ Condom
□ Diaphragm
□ Tubal Ligation
□ Vasectomy
□ Nexplanon Implant
□ Depo Shot
□ Birth Control Patch
□ Natural Family Planning
□ None

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Patient Name:_____ Today's Date:_____

Family History

Check any diseases that run in your family:

	Mother	Father	Sister	Brother	Grandmother (mother's side)	Grandfather (mother's side)	Grandmother (father's side)	Grandfather (father's side)	Other
Alcoholism									
Arthritis									
Bleeding Disorder									
Depression									
Diabetes									
Drug Abuse									
Cancer *type: _____									
Genetic Disease									
Heart Attack									
High Blood Pressure									
High Cholesterol									
Mental Illness									
Osteoporosis									
Obesity									
Seizures/Convulsions									
Stroke									
Thyroid Disease									

Please specify if there are any other diseases that run in your family that are not listed:

_____

REVIEW OF SYSTEMS

Have you had any of the following in the last 6 months?

- ☐ Weight Loss
- ☐ Fever
- ☐ Vision Changes
- ☐ Sinus Problems
- ☐ Headaches/Migraines
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Numbness/Nerve Pain
- ☐ Frequent Bruises/Easy Bleeding
- ☐ Swelling of Legs
- ☐ Chest Pain
- ☐ Heart Palpitations
- ☐ Wheezing/Shortness of Breath
- ☐ Cough
- ☐ Frequent Diarrhea
- ☐ Nausea/Vomiting
- ☐ Heartburn
- ☐ Frequent Constipation
- ☐ Blood With Urination
- ☐ Urine Incontinence/Dribbling
- ☐ Rash/Skin Lesions
- ☐ Discharge from Breasts
- ☐ Masses on Skin/Breasts
- ☐ Pain/Bleeding after Sex
- ☐ Sexual Problems
- ☐ Abnormal Vaginal Symptoms
- ☐ Hot Flashes
- ☐ Depression (Crying, Moodiness)
- ☐ Anxiety

Other/Additional Information:_____

_____

_____

Personal History

Are you currently married or living with a partner or significant other? ☐ Yes ☐ No
Who lives with you at home? _____

Are you employed? ☐ Yes ☐ No ☐ Retired
If yes, what kind of work do you do? _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things.	0	1	2	3
Feeling down, depressed, or hopeless.	0	1	2	3