# Health Questionnaire

PRIMARY CARE (719) 522-1133

***Please help us in meeting your health care needs by providing the following information.***
****Children under 13, please use Pediatric Health History only. Thank you!***

Patient: ______________________________ Today's Date: ____________________

Date of Birth: ____________________ Who is your visit with? ______________________________

**What is your reason for coming in today?**

______________________________________________________________________

**PAST MEDICAL HISTORY:**

List all *medical illnesses you have had, including the date of diagnosis:*

| ***Illness/Medical Condition:*** | ***Treated by:*** | ***Date:*** |
|---|---|---|
| | | |
| | | |
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| | | |
| | | |
| | | |
| | | |

List any surgeries you have had, including dates if known:

| ***Surgery:*** | ***Treated by:*** | ***Date:*** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

List any medications you are now taking, including all non-prescription, over-the-counter, vitamins and herbal:

| ***Medication:*** | ***Dose:*** | ***How Taken:*** |
|---|---|---|
| | | |
| | | |
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**Patient Name:** ______________________________ **Date of Birth:** ____________________

**ALLERGIES**

**Drugs/medications:** ______________________________________________________________

**Known food allergies:** ____________________________________________________________

**Have you ever had any of the following health maintenance testing?** (If so, enter date or year):

Mammogram: ____________ Colonoscopy:____________ DEXA (Bone Scan): _____________

Chest X-Ray: _____________ EKG: _____________ PAP: ____________

Lab(s): *cholesterol* _______________ *blood sugar* ________ *thyroid* _____ *other:*_______

**IMMUNIZATIONS** Please list the immunizations you have had, noting the estimated date.

_______**Tetanus** _______ **Polio** _______ **Pneumovax** _______ **Hepatitis**

_______**Shingles** _______ **Influenza** _______**Measles/Mumps/Rubella**

**SOCIAL HISTORY:** (Circle one)

Marital Status: Single Married Separated Divorced Widowed

Use of Alcohol: Never Rarely Moderate Daily

Use of Tobacco: Never Previously, but quit ________ Current: packs/day ________

Use of Vapors/E-Cigs: Never Type/frequency: ______________________________________

Use of Marijuana: Never Frequency: __________________________________________

Use of Drugs: Never Type/frequency: _____________________________________________

Excessive exposure at home or work to: Fumes Dust Solvents Airborne particles Noise

Are you on any special diet? If so, what type of diet? ______________________________________

Do you think you eat nutritiously? ☐ yes ☐no, why ______________________________________

Are you concerned with your weight? ☐no ☐yes

Do you exercise regularly? ☐no ☐yes, what type? _____________________________________

<u>**SEXUALITY:**</u> Gender: ☐Male ☐Female

How do you identify? ☐Heterosexual ☐Lesbian ☐Gay ☐Transgender ☐Bi-sexual ☐Other

Are you sexually active? ☐yes ☐no Any concerns? ______________________________

**MEDICAL HISTORY**

**Family Medical History:**

**Mother's Age:** ______ **Deceased?** ☐**No** ☐ **Yes, cause of death:** ______________________________

**Father's Age:** ______ **Deceased?** ☐**No** ☐ **Yes, cause of death:** ______________________________

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Patient Name: ________________________ Date of Birth: ________________

| CONDITION | CIRCLE ONE | | WHICH FAMILY MEMBER? |
|---|---|---|---|
| High Blood Pressure | No | Yes | ______________ |
| Heart Disease | No | Yes | ______________ |
| Diabetes | No | Yes | ______________ |
| Cancer | No | Yes | ______________ |
| Kidney Failure | No | Yes | ______________ |
| Mental Illness | No | Yes | ______________ |
| Alcoholism | No | Yes | ______________ |
| Tuberculosis | No | Yes | ______________ |
| Thyroid | No | Yes | ______________ |

**Are there any other illnesses that run in your family?** ______________

**Menstrual History:** **WOMEN ONLY**

How old were you when you started your periods? ________

Are you post-menopausal? ☐no ☐yes, date of last period ______________

Are your periods regular? ☐yes ☐no, explain ______________

If regular, how many days lapse between your periods

(for example, the average cycle is 28 to 32 days) ______________

How many days do you flow? _______ Describe flow ______________

Do you suffer from menstrual cramps or other menstrual problems? ☐no ☐yes, explain______________

**Pregnancy History** ***If you have ever been pregnant, please answer the following:***

How many children do you have? __________ Number of abortions or miscarriages: ____________

Did you have any complications with your pregnancies? ☐no ☐yes, explain ______________

Have you had an ectopic pregnancy? ☐no ☐yes, how many? ____________

What form of birth control are you using (i.e., Pill, IUD)? ______________

**Do you have a "Living Will" and/or "Advanced Directives"?** ☐**No** ☐**Yes (if so, please provide a copy)**

**Would you like information on these documents?** ☐**No** ☐**Yes**

**Authorization & Release:**
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health and it is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

______________________________ ______________

**Signature of patient (or parent/guardian if minor)** **Date**

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# Pediatric Health History

FAMILY MEDICINE 719-522-1133

MRN: ____________________ *(Office use only)*

**Patient Name:** ______________________________ **Date of Birth:** ______________

Name child goes by: ____________________________

**ALLERGIES**: ☐ NONE

Medication: ________________________________________

Food: ________________________________________

Environmental: ________________________________________

**MEDICATIONS**: ☐ NONE

Prescription: ________________________________________

Over-the-Counter: ________________________________________

**DIET:** Infant: ☐ Breast ☐ Formula: ______________________________

Child: ☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten-free

☐ Other: ________________________________________

**IMMUNIZATIONS**: ☐ Up-to-Date ☐ Behind ☐ NONE

**ACTIVE MEDICAL PROBLEMS:** ☐ NONE

☐ Asthma ☐ Allergies ☐ ADHD ☐ Eczema ☐ Diabetic ☐ Seizures ☐ Ear Infections

☐ Bed Wetting ☐ Constipation ☐ Recurrent UTI ☐ Hypertension

☐ Concussions ☐ Depression ☐ Glasses

☐ Developmental Delay: ☐ Speech ☐ Gross Motor ☐ Fine Motor ☐ Social

☐ Other: ________________________________________

**PAST MEDICAL:**

**Birth History:** ☐ Vaginal ☐ C-section ☐ Weight: ____________________

☐ Term ☐ Preterm: ________weeks

**Medical History:** ☐ NONE

Hospitalizations: ________________________________________

Specialists seen: ________________________________________

Other: ________________________________________

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**Patient Name:** ______________________________ **Date of Birth:** ____________________

**Surgical History:** ☐ NONE

☐ Ear Tubes ☐ Tonsils ☐ Adenoids ☐ Appendix ☐ Hernia

☐ Other: ____________________________________________

☐ Fractures: __________________________________________

**FAMILY HISTORY:** ☐ NONE

| | Mother | Father | Sibling | Relative |
|---|---|---|---|---|
| Asthma | ☐ | ☐ | ☐ | ☐ |
| Allergies | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ |
| Hypertension | ☐ | ☐ | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ |
| ADHD | ☐ | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ | ☐ |
| Migraines | ☐ | ☐ | ☐ | ☐ |
| High Cholesterol | ☐ | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ | ☐ |

**SCHOOL AND ACTIVITIES:**

☐ Daycare ☐ Public School ☐ Private School ☐ Home School

Grade: __________ IEP: ☐ Yes

Sports: ____________________________________________

Activities: __________________________________________

**FAMILY STRUCTURE:**

Parents: ☐ Single ☐ Married ☐ Divorced ☐ Remarried

Custody: ☐ N/A ☐ Joint ☐ Mother ☐ Father

☐ Other: ______________________________________

Mother's Name: ______________________________________

Father's Name: ______________________________________

Step-Parents: ______________________________________

Siblings: ______________________________ Age: __________

______________________________ Age: __________

______________________________ Age: __________

______________________________ Age: __________

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NAME ______________________________________________

**REVIEW OF SYMPTOMS: Please check any of the following if you are currently experiencing symptoms:**

| GENERAL | EYES | ENT | RESPIRATORY | CARDIO |
|---|---|---|---|---|
| __ Fever<br>__ Chills<br>__ Feeling tired<br>__ Feeling poorly<br>__ Weight gain<br>__ Weight loss | __ Vision problems<br>__ Red eye<br>__ Eye pain<br>__ Eye discharge<br>__ Dry eyes<br>__ Itchy eyes | __ Ear pain<br>__ Hearing loss<br>__ Nose bleeds<br>__ Nasal discharge<br>__ Sore throat<br>__ Hoarseness | __ Short of breath<br>__ Awaken short of breath at night (PND)<br>__ Cough - dry<br>__ Short of breath w/ exertion<br>__ Hurts to breathe<br>__ Short of breath lying down<br>__ Wheezing<br>__ Cough - productive | __ Chest pain<br>__ Palpitations<br>__ Lower leg swelling<br>__ Heart rate slow<br>__ Lower leg clot<br>__ Heart rate fast |
| **GASTRO** | **URINARY** | **REPRODUCTIVE** | **MUSCULOSKELETAL** | **NEUROLOGICAL** |
| __ Abdominal pain<br>__ Constipation<br>__ Heartburn<br>__ Vomiting<br>__ Blood in stool<br>__ Nausea<br>__ Diarrhea<br>__ Difficulty swallowing | __ Pain w/urination<br>__ Urination at night<br>How often?_____<br>__ Hesitancy<br>__ Loose bladder Control<br>__ Flank pain<br>__ Pass kidney stones<br>__ Pelvic pain | __ Painful menstrual cycle<br>__ Vaginal discharge<br>__ Pain w/intercourse<br>__ Abnormal vaginal Bleeding<br>__ Testicular pain<br>__ Erectile dysfunction<br>__ Premature ejaculation<br>__ Genital lesions<br>__ Decreased libido | __ Joint pain<br>__ Joint swelling<br>__ Joint stiffness<br>__ Limb pain<br>__ Limb swelling | __ Headaches<br>__ Confused<br>__ Dizziness<br>__ Fainting<br>__ Limb weakness<br>__ Convulsions<br>__ Difficulty walking<br>__ Numbness upper extremity<br>__ Numbness lower extremity |
| **INTEGUMENTARY** | **PSYCHIATRIC** | **ENDOCRINE** | **HEM/LYMPH** | **ALLERGY** |
| __ Skin lesions<br>__ Skin wound<br>__ Itching<br>__ Change in mole<br>__ Skin rash<br>__ Dry skin<br>__ Breast pain<br>__ Breast lump | __ Depression<br>__ Suicidal<br>__ Anxiety<br>__ Sleep disturbances<br>__ Personality changes<br>__ Emotional problems | __ Feels weak<br>__ Hot flashes<br>__ Muscle weakness<br>__ Deeper voice<br>__ Bulging eyes (proptosis) | __ Bleeds easily<br>__ Bruises easily<br>__ Swollen glands<br>__ Swollen glands in neck | __ Allergic reaction<br>__ Recurrent infection |

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**NAME** ________________________________________________

**REVIEW OF SYMPTOMS: Please check any of the following if you are currently experiencing symptoms:**

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