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Health questionnaire

Primary care 1-719-522-1133 TTY **711**

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:**
_____	_____	_____ / _____ / _____
_____	_____	_____ / _____ / _____
_____	_____	_____ / _____ / _____
_____	_____	_____ / _____ / _____
_____	_____	_____ / _____ / _____

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 check the immunizations you have had, noting the estimated date.

☐ ____ / ____ / ____ **Tetanus** ☐ ____ / ____ / ____ **Polio** ☐ _____ / _____ / _____ **Pneumovax**

☐ ____ / ____ / ____ **Hepatitis** ☐ ____ / ____ / ____ **Shingles** ☐ _____ / _____ / _____ **Influenza**

☐ ____ / ____ / ____ **Measles/Mumps/Rubella**

Social history: (check 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? ☐ Yes ☐ No If yes, what type of diet? _____

Do you think you eat nutritiously? ☐ Yes ☐ No, why _____

Are you concerned with your weight? ☐ Yes ☐ No

Do you exercise regularly? ☐ No ☐ Yes, what type(s)? _____

Sexuality: Gender: ☐ Male ☐ Female

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

Are you sexually active? ☐ Yes ☐ No Any concerns? _____

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	Check 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? _____

Women only–Menstrual history:

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 advance directive? ☐ 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 health care staff to perform the necessary services I may need.

_____ _____ / _____ / _____

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

Name: _____

Review of symptoms: Please check any of the following if you are currently experiencing symptoms:

General	**Eyes**	**ENT**	**Respiratory**	**Cardio**
☐ Fever	☐ Vision problems	☐ Ear pain	☐ Short of breath	☐ Chest pain
☐ Chills	☐ Red eye	☐ Hearing loss	☐ Awaken short of breath at night (PND)	☐ Palpitations
☐ Feeling tired	☐ Eye pain	☐ Nose bleeds	☐ Cough - dry	☐ Lower leg swelling
☐ Feeling poorly	☐ Eye discharge	☐ Nasal discharge	☐ Short of breath with exertion	☐ Heart rate slow
☐ Weight gain	☐ Dry eyes	☐ Sore throat	☐ Hurts to breathe	☐ Lower leg clot
☐ Weight loss	☐ Itchy eyes	☐ Hoarseness	☐ Short of breath lying down	☐ Heart rate fast
			☐ Wheezing	
			☐ Cough - productive	

Gastro	**Urinary**	**Reproductive**	**Musculoskeletal**	**Neurological**
☐ Abdominal pain	☐ Pain w/urination	☐ Painful menstrual cycle	☐ Joint pain	☐ Headaches
☐ Constipation	☐ Urination at night	☐ Vaginal discharge	☐ Joint swelling	☐ Confused
☐ Heartburn	☐ How often? _____	☐ Pain with intercourse	☐ Joint stiffness	☐ Dizziness
☐ Vomiting	☐ Hesitancy	☐ Abnormal vaginal	☐ Limb pain	☐ Fainting
☐ Blood in stool	☐ Loose bladder control	☐ Bleeding	☐ Limb swelling	☐ Limb weakness
☐ Nausea	☐ Flank pain	☐ Testicular pain		☐ Convulsions
☐ Diarrhea	☐ Pass kidney stones	☐ Erectile dysfunction		☐ Difficulty walking
☐ Difficulty swallowing	☐ Pelvic pain	☐ Premature ejaculation		☐ Numbness upper extremity
		☐ Genital lesions		☐ Numbness lower extremity
		☐ Decreased libido		

Integumentary	**Psychiatric**	**Endocrine**	**HEM/Lymph**	**Allergy**
☐ Skin lesions	☐ Depression	☐ Feels weak	☐ Bleeds easily	☐ Allergic reaction
☐ Skin wound Itching	☐ Suicidal	☐ Hot flashes	☐ Bruises easily	☐ Recurrent infection
☐ Change in mole	☐ Anxiety	☐ Muscle weakness	☐ Swollen glands	
☐ Skin rash	☐ Sleep disturbances	☐ Deeper voice	☐ Swollen glands in neck	
☐ Dry skin	☐ Personality changes	☐ Bulging eyes (proptosis)		
☐ Breast pain	☐ Emotional problems			
☐ Breast lump				

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