CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE – PAST MEDICAL HISTORY
ALL ABOUT FAMILY MEDICINE (NEW PATIENTS ONLY)

NAME:_____ DATE OF BIRTH:_____ AGE:_____ DATE:_____

ALLERGIES

(list any allergies to medicines or other substances) ☐ None

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SURGERY / HOSPITALIZATION

Date Reason ☐ None

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

MEDICAL PROBLEMS

List any chronic or recurrent medical problems – Date of onset
☐ None

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

LIST ALL MEDICATION YOU TAKE REGULARLY (PRESCRIPTION AND NON-PRESCRIBITION)

Medicine Dose ☐ None

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

CHECK ANY THAT YOU HAVE HAD OR NOW HAVE

PAST / CURRENT	PAST / CURRENT
☐☐ Abnormal Electrocardiogram	☐☐ Heart Attack
☐☐ Abnormal Pap Smear	☐☐ Heart Murmur/ Heart Disease
☐☐ AIDS or HIV	☐☐ Hepatitis or Cirrhosis
☐☐ Alcohol Drug Overuse/Abuse	☐☐ Herniated / Ruptured Disc
☐☐ Allergies or Hay Fever	☐☐ Herpes
☐☐ Anemia (low iron)	☐☐ High Blood Pressure
☐☐ Ankles Swell Frequently	☐☐ Hodgkin's Disease, Leukemia or Lymphoma
☐☐ Anxiety of Panic Attacks	☐☐ Intolerance of Dairy / Fatty Foods
☐☐ Arthritis or Grout	☐☐ Irregular Heartbeat
☐☐ Asthma	☐☐ IBS
☐☐ Frequent Backaches	☐☐ Kidney Disease / Nephritis
☐☐ Bladder Infection	☐☐ Kidney Stones
☐☐ Blood Clots / Bleeding Prob.	☐☐ Lung Problems
☐☐ Blood in Bowel Movement	☐☐ Lupus
☐☐ Blood Transfusion	☐☐ Malaria
☐☐ Boils / Cysts - Recurrent	☐☐ Seizures, Convulsions, Epilepsy
☐☐ Bone or Joint Disease	☐☐ Meningitis
☐☐ Bowel or Colon Disease	☐☐ Migraine Headaches
☐☐ Breast Lumps	☐☐ Mole Changes
☐☐ Bronchitis – Recurrent	☐☐ Muscle Disease / Weakness
☐☐ Bruise Easily	☐☐ Pancreatitis
☐☐ Bursitis/ Tendonitis	☐☐ Phlebitis
☐☐ Cancer	☐☐ Pleurisy
☐☐ Chest Pain	☐☐ Pneumonia
☐☐ Chills / Night Sweats	☐☐ Polio
☐☐ Elevated Cholesterol	☐☐ Urination Problems
☐☐ Chronic Cough	☐☐ Rheumatoid Arthritis
☐☐ Colitis	☐☐ Rheumatic Fever
☐☐ Color-Blindness	☐☐ Sensory Changes
☐☐ Concerns about Fertility	☐☐ Sexual Problems /Concerns
☐☐ Concussion / Head Injury	☐☐ Shortness of Breath
☐☐ Constipation	☐☐ Sickle Cell Disease / Trait
☐☐ Depression or Suicide	☐☐ Skin Disease – Chronic
☐☐ Diabetes	☐☐ Skin Infections - Recurrent
☐☐ Difficulty Swallowing	☐☐ Sleep Disorder / Difficulty
☐☐ Dizziness or Fainting	☐☐ Sprains or Dislocations
☐☐ Emphysema	☐☐ Stomach Pain
☐☐ Excessive Stress	☐☐ Stroke or Brain Attack
☐☐ Frequent Cold/ Sinus Prob.	☐☐ Swelling of Joints
☐☐ Frequent Earaches	☐☐ Thyroid Disease
☐☐ Frequent Painful Urination	☐☐ Tremors/ Shaking of Hands
☐☐ Frequent/Severe Sore Throat	☐☐ TB or Positive Trait
☐☐ Frequent/Severe Nose Bleeds	☐☐ Ulcer Disease or Gastritis
☐☐ Gallbladder Dis./ Gallstones	☐☐ Unexpected Weight Loss
☐☐ Glaucoma	☐☐ Urinate Frequently at Night
☐☐ Gonorrhea, Chlamydia, or Syphilis	☐☐ Varicose Veins
☐☐ Growth on skin Gum bleed	☐☐ Venereal Disease
☐☐ Easily Frequent Sore Throat	☐☐ Wheezy / Whistling Chest
☐☐ Hearing Problems	☐☐ Yellow Jaundice

IMMUNIZATION HISTORY

		Date of Last
Chickenpox or Shot	☐ Yes ☐ No	_____
Hepatitis B Series or Shot	☐ Yes ☐ No	_____
Influenza Shot	☐ Yes ☐ No	_____
Pneumonia Shot	☐ Yes ☐ No	_____
Rubella Shot or Blood Test	☐ Yes ☐ No	_____
Tetanus Shot	☐ Yes ☐ No	_____

FAMILY HISTORY

	If Alive, Age	If Dead, Age and Cause
Father		
Mother		
Brother / Sister		
Brother / Sister		
Brother / Sister		
Brother / Sister		
Spouse / Sig. Other		
Son / Daughter		
Son / Daughter		
Son / Daughter		

Primary Language in Home _____

PLEASE CHECK FOR ANY CONDITION WHICH APPLIES TO A BLOOD RELATIVE

Condition	Who
☐ Alcohol / Drug Abuse	_____
☐ Allergies / Asthma	_____
☐ Arthritis / Gout	_____
☐ Bleeding Disorder	_____
☐ Cancer (Type)	_____
☐ Diabetes	_____
☐ Epilepsy / Seizures	_____
☐ Glaucoma	_____
☐ Heart Disease	_____
☐ High Blood Pressure	_____
☐ High Cholesterol	_____
☐ HIV / AIDS	_____
☐ Kidney Disease	_____
☐ Mental Illness	_____
☐ Migraine Headaches	_____
☐ Sickle Cell Condition	_____
☐ Stroke	_____
☐ Suicide / Depression	_____
☐ Thyroid Disease	_____

SOCIAL HISTORY

Do you use drugs? ☐ Yes ☐ No
With Whom do you Now Live?_____
Highest Education Received?_____
Your Occupation?_____
Exposure to Hazardous Conditions/Substances ☐ Yes ☐ No
Type_____
Religious Beliefs / Preferences_____
Do you have a Living Will? ☐ Yes ☐ No
Are you an Organ Donor? ☐ Yes ☐ No

PERSONAL HISTORY

QUESTIONS FOR WOMAN ONLY

MENSTRUATION:

Age Period Began _____ How Often_____
Date of Last Menstrual Period_____
Now Pregnant? ☐ Yes ☐ No
Vaginal Discharge? ☐ Yes ☐ No
PMS? ☐ Yes ☐ No
Menopause? ☐ Yes ☐ No
Unexplained Vaginal Discharge? ☐ Yes ☐ No
Discharge from Nipples? ☐ Yes ☐ No
Skin Changes in Breasts? ☐ Yes ☐ No

PREGNANCIES:

Total Number_____ Full Term_____
Date of Last Pap Smear _____
Date of last Mammogram _____
Premature_____
Miscarriages_____
Abortions_____
Tubal Pregnancies_____

QUESTIONS FOR MEN ONLY

Prostate Trouble ☐ Yes ☐ No
Discharge from Penis? ☐ Yes ☐ No
Sore on Penis? ☐ Yes ☐ No
Do you Examine your Testicles? ☐ Yes ☐ No

QUESTIONS FOR MEN AND WOMEN

What kind of Birth Control/Protection do you and/or your partner use?_____
How would you describe your sexual orientation_____
Do you use sunscreen? ☐ Yes ☐ No
Do you always wear seatbelts? ☐ Yes ☐ No
Do you wear protective sports equipment? ☐ Yes ☐ No
Smoke free House? ☐ Yes ☐ No
Do you have a working smoke detector? ☐ Yes ☐ No
Are there weapons/guns in your house? ☐ Yes ☐ No
Do you floss regularly? ☐ Yes ☐ No
Do you wear dentures? ☐ Yes ☐ No
Last Dental Visit? Date: _____
Do you wear glasses/contacts? ☐ Yes ☐ No
Last eye exam? Date: _____

DIET AND EXCERISE HABITS:

Do you follow a special diet? If so, explain._____
Current Weight?_____ Desired?_____One Year Ago?_____
What kind of exercise?_____ How Often?_____

TOBACCO USE:

Do you smoke?_____ What type?_____
If yes, how much per day?_____Per Week?_____
Have you quit smoking?_____When?_____
Do you use other tobacco?_____Type?_____
If so, how much?_____

ALCOHOL USE:

Do you drink alcohol?_____ How many drinks per week?_____
Has anyone ever expressed concerns about your use?_____
If yes, explain.