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PERSONAL HEALTH HISTORY

Name *(Last, First, M.I.):*		☐ F ☐ M	**DOB:**
Marital status:	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other		
Other Physicians Seen:			**Email Address:**
Pharmacy:	**Phone:**		**Address:**
Mail order pharmacy (if you use one):			
Immunizations and dates:	☐ Tetanus	☐ Pneumovax 23	☐ Tetanus+Whooping Cough
	☐ Hepatitis A	☐ Influenza	☐ Zostavax (Shingles)
	☐ Hepatitis B	☐ Gardasil	☐ Prevnar 13

List any medical problems you currently have and significant illnesses in the past:

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.				
Exercise	☐ Sedentary (No exercise)			
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	How would you describe your diet?			
	☐ Healthy	☐ Needs improvement	☐ Confused about what to eat	
	Are you following any weight loss or other diet?	☐ Yes ☐ No	If yes, what diet:	
Alcohol	Do you drink alcohol?			☐ Yes ☐ No
	If yes, what kind?	How many drinks per week?		
	Have you ever had a problem with alcohol in the past?			☐ Yes ☐ No
	Are you concerned about the amount you drink?			☐ Yes ☐ No
Tobacco	Do you use tobacco? Please check one			
	☐ Never smoked	☐ Current smoker	☐ Former smoker	☐ Occasional smoker
	Cigarettes per day:	Chew per day:	Pipes per day:	Cigars per day:
	Number of years using tobacco:	Year quit:		
Drugs	Do you currently use recreational or street drugs?			☐ Yes ☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes ☐ No

HEALTH HABITS AND PERSONAL SAFETY - CONTINUED

HIV and Hepatitis C	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak to your provider about your risk of this illness?	☐ Yes	☐ No
	The risk of contracting Hepatitis C is increased in people who have a history of intravenous drug use or receiving blood transfusions before 1992. Also, a one-time screening test is recommended for all adults born between 1945 and 1965. Would you like to discuss this screening?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Is there any concern that you or a family member may be a victim of physical or verbal abuse?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father	☐ Alive ☐ Deceased Age:		**Children**	☐ M ☐ F	
				☐ M ☐ F	
Mother	☐ Alive ☐ Deceased Age:			☐ M ☐ F	
				☐ M ☐ F	
Siblings	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MEN ONLY

How many times do you normally get up at night to urinate:	☐ 0	☐ 1	☐ 2	☐ 3 or more
Has the force of your urination decreased?			☐ Yes	☐ No
Any difficulty with erection or ejaculation?			☐ Yes	☐ No
Any testicular pain or swelling?			☐ Yes	☐ No
For the next two items, please provide the date of the last exam, and the name of the doctor or provider				
Colonoscopy:				
PSA blood test:				

WOMEN ONLY

Age at onset of menstruation:	Menopausal:	☐ Yes ☐ No
Number of pregnancies:	Number of live births:	
Are you having heavy or irregular periods, cramps, PMS, vaginal discharge, dryness or painful intercourse?	☐ Yes	☐ No
Details if you answered yes to the previous question:		
Any menopausal symptoms that bother you?	☐ Yes	☐ No
Details if you answered yes to the previous question:		
Any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Details if you answered yes to the previous question:		
For the next four items, please provide the date of the last exam, and the name of the doctor or provider		
PAP test or Pelvic exam:		
Mammogram:		
Bone density:		
Colonoscopy:		

MENTAL HEALTH

Over the last two weeks, how often have you been bothered by 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
Trouble falling or staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	☐ 0	☐ 1	☐ 2	☐ 3
Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	☐ 0	☐ 1	☐ 2	☐ 3
Thoughts that you would be better off dead or of hurting yourself in some way	☐ 0	☐ 1	☐ 2	☐ 3

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.	
☐ Fatigue	☐ Chest pain
☐ Weight loss or gain	☐ Palpitations
☐ Headache	☐ Shortness of breath
☐ Allergy symptoms	☐ Cough
☐ Vision changes	☐ Wheeze
☐ Dizziness	☐ Heartburn
☐ Insomnia	☐ Indigestion
☐ Daytime sleepiness	☐ Diarrhea
☐ Constipation	☐ Hemorrhoids
☐ Urinary problems	☐ Joint ache
☐ Back or neck pain	☐ Edema or swelling
☐ Vein problems	☐ Numbness
☐ Anxiety	☐ Gas/bloating
☐ Sexual problems	☐ Substance abuse concern
Other concerns or added detail for the items checked above:	