

Emerald City Medical Arts

Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> TG		DOB:	
Occupation:					
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					
Previous or referring doctor:				Date of last physical exam:	
IMMUNIZATION/ILLNESS/HOSPITALIZATION HISTORY					
Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio					
Immunizations and dates:	<input type="checkbox"/> Hepatitis A		<input type="checkbox"/> Hepatitis B		<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Tetanus		<input type="checkbox"/> Zostavax		<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza		<input type="checkbox"/> Gardasil		<input type="checkbox"/> MMR
Surgeries / Hospitalizations					
Year	Reason				Hospital
Have you ever had a blood transfusion?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				Month	Year
MEDICATION HISTORY					
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	<input type="checkbox"/> No exercise <input type="checkbox"/> Mild <input type="checkbox"/> Occasional vigorous exercise <input type="checkbox"/> Regular vigorous exercise (more than 3x per wk) Type:				
Diet	Are you dieting?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Caffeine	<input type="checkbox"/> None		<input type="checkbox"/> Coffee <input type="checkbox"/> Tea		<input type="checkbox"/> Cola
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, how many drinks per week?				
Tobacco	Do you use tobacco?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day		<input type="checkbox"/> Chew - #/day		<input type="checkbox"/> Pipe - #/day
	<input type="checkbox"/> # of years		<input type="checkbox"/> former smoker, quit date?		

Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sex	Are you sexually active? w/ <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sexually transmitted diseases and illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, have become a major public health problem. Risk factors for these illnesses include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of these illnesses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY (Check all that apply and list family relation)	
<input type="checkbox"/> Diabetes:	<input type="checkbox"/> Stroke:
<input type="checkbox"/> Hypertension:	<input type="checkbox"/> Heart Disease:
<input type="checkbox"/> Cancer/Type:	<input type="checkbox"/> Other:

MEDICAL ILLNESSES/CONDITIONS		
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain and date of last onset		
<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Goiter
<input type="checkbox"/> Seizures or Convulsions	<input type="checkbox"/> Ulcer(s)	<input type="checkbox"/> Gonorrhea
<input type="checkbox"/> Stroke	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Polio	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Chlamydia
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Gall stones	<input type="checkbox"/> HIV
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Herpes
<input type="checkbox"/> Blindness	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Chicken pox
<input type="checkbox"/> Recurrent ear infections	<input type="checkbox"/> Urinary trouble	<input type="checkbox"/> Mumps
<input type="checkbox"/> Deafness	<input type="checkbox"/> Bowel trouble	<input type="checkbox"/> Measles
<input type="checkbox"/> Hay fever, Allergies	<input type="checkbox"/> Dysentery	<input type="checkbox"/> Recurrent boils
<input type="checkbox"/> Recurrent sinusitis	<input type="checkbox"/> Rectal trouble	<input type="checkbox"/> Skin problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Depression
<input type="checkbox"/> Chronic bronchitis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Emotional
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Gout	Women
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Broken Bones	<input type="checkbox"/> First day of last menstrual:
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Menstrual problem(s)
<input type="checkbox"/> Angina	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Abnormal PAP
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Bleeding trouble	<input type="checkbox"/> Ovarian cyst(s)
<input type="checkbox"/> Enlarged heart	<input type="checkbox"/> Anemia	<input type="checkbox"/> Breast lump(s)
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Cancer (list):	Men
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Prostate trouble
<input type="checkbox"/> Hernia	<input type="checkbox"/> Thyroid	
List any medical problems that other doctors have diagnosed:		

Sign _____ Date _____