Health History Questionnaire

Name: _____ Sex: ____ Date of Birth: _____

List any medical problems that you have had:

Check if you have, or have had any symptoms in the following areas to a significant degree:

☐ Chest Pain
☐ Irregular Pulse
☐ Fainting
☐ High Blood Pressure
☐ Wheezing
☐ Pneumonia
☐ Thyroid Disease
☐ Diarrhea
☐ Blood in Stool
☐ Hepatitis A B C (circle one)
☐ Swallowing Problems
☐ Urinary Frequency
☐ Kidney Stones
☐ Hearing Problems
☐ Foot Pain
☐ Shortness of Breath
☐ Heart Murmur
☐ Stroke
☐ High Cholesterol
☐ COPD
☐ High Blood Sugar
☐ Loss of Appetite
☐ Constipation
☐ Gall Bladder Disease
☐ Abdominal Pain
☐ Heartburn
☐ Incontinence
☐ Headache
☐ Vision Problems
☐ Arthritis
☐ Palpitations
☐ Other Heart Problems
☐ Seizure
☐ Asthma
☐ Chronic Cough
☐ Diabetes
☐ Fatigue
☐ Change in Bowel Habits
☐ Pancreatitis
☐ Ulcers
☐ Urine Infections (chronic)
☐ Blood in Urine
☐ Menstrual Problems
☐ Back Pain
☐ Skin Problems:_____
☐ Other:_____

Medications

List any medications you are currently taking (prescribed and over the counter):

Allergies to Medications

List the drug name and the reaction:

Preferred Pharmacy (include name and location):

Family History

List any significant health problems in your family history:

Social History

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____	Tobacco Use (please check one): ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked
Exercise (please check one): ☐ Sedentary (No exercise) ☐ Mild exercise (work or recreation 1-2 times/week) ☐ Occasional vigorous exercise (3-4 s/ week) ☐ Regular vigorous exercise (≥ 4 times/week for 30 min)	Are you sexually active? ☐ Yes ☐ No If yes, are you trying for a pregnancy? ☐ Yes ☐ No If not trying for pregnancy, list contraceptive or barrier method used: _____ Any discomfort with intercourse? ☐ Yes ☐ No

Mental Health

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

Surgeries/Hospitalizations (specify reason/type and location):

Additional Information:
