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