**Strong Internal Medicine**

**Health History Questionnaire**

*(please print clearly)*

**Patient Information**:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: ❑ Single ❑ Married ❑ Divorced/ Separated ❑ Partnered

**Medical Information**:

Do you have any major health concerns or questions that you would like to discuss with the health care provider*? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Past Medical History**:*(Check all items that apply to you and fill in the blanks as needed)*

\_\_allergies

\_\_anemia or blood problems

\_\_arthritis

\_\_asthma

\_\_blood transfusion, year\_\_\_\_\_\_\_\_

\_\_cancer/tumor, type\_\_\_\_\_\_\_\_\_\_\_

\_\_chickenpox, year\_\_\_\_\_\_\_\_\_

\_\_COPD/emphysema

\_\_diabetes

\_\_drug or alcohol abuse

\_\_epilepsy or seizure

\_\_hearing loss

\_\_heart disease or heart attack

\_\_hepatitis

\_\_HIV/AIDS

\_\_high blood pressure

\_\_kidney disease or stones

\_\_ulcer disease or reflux

\_\_depression/anxiety

\_\_other mental illness

\_\_sexually-transmitted disease

\_\_skin disease, eczema, psoriasis

\_\_stroke

\_\_thyroid disease

\_\_other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Medications:** (*List all medications with dosages, include over-the-counter medications and herbs*)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies:**

❑ No known drug allergies

Allergic to Drug:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Drug:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ No known food or environmental allergies (peanuts, bees, pollen, etc)

 Allergic to Food/Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Food/Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preventive Services:** (*Please list the date that you last had these tests or procedures.)*

Physical: ❑ Never or Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Lipid/cholesterol panel: ❑ Never or Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Colonoscopy: ❑ Never or Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Bone density or DEXA scan: ❑ Never or Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Immunizations

 Tetanus Date \_\_\_\_\_\_\_\_\_\_\_ Influenza (Flu) Date \_\_\_\_\_\_\_\_\_\_\_

 Hepatitis B Date \_\_\_\_\_\_\_\_\_\_\_ Pneumonia Date \_\_\_\_\_\_\_\_\_\_\_

 Chicken Pox Date \_\_\_\_\_\_\_\_\_\_\_ Gardasil (HPV) Date \_\_\_\_\_\_\_\_\_\_\_

 Zoster (shingles) Date \_\_\_\_\_\_\_\_\_\_\_

If you do not know your immunization history, please indicate the doctor or office that may have immunization records:

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Women Only:** Date of last Pap smear:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last mammogram:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Risk Assessment/Social History:**

Do you currently smoke? ❑ No ❑ Yes If yes, how many packs per day \_\_\_\_ for how many years \_\_\_\_\_

Did you smoke in the past? ❑ No ❑ Yes If yes, when did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had exposure to smoke now or in the past? ❑ No ❑ Yes How long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many alcoholic drinks do you have in a typical day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you used illegal or recreational drugs in the past year? ❑ No ❑ Yes

Has anyone complained about your drug or ETOH use? ❑ No ❑ Yes

How many caffeinated beverages do you have per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you on a special diet (vegetarian, gluten free, etc)? ❑ No ❑ Yes If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours of sleep do you get on a typical night? \_\_\_\_\_\_\_\_\_

Do you exercise regularly? ❑ No ❑ Yes (specify how often) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear helmets for sports (biking, skiing, etc)? \_\_No \_\_Yes \_\_ N/A

Do you use a seatbelt? ❑ No ❑ Yes

Do you use contraception if you are sexually active? ❑ No ❑ Yes ❑ N/A

Do you practice safe sex if you are sexually active? ❑ No ❑ Yes ❑ N/A

Have you ever been a victim of abuse? ❑ No ❑ Yes When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been exposed to hazardous material? ❑ No ❑ Yes If yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have smoke detectors in your home? ❑ No ❑ Yes

Do you have carbon monoxide detectors in your home? ❑ No ❑ Yes

Have you often been bothered by feeling down, depressed, or hopeless? ❑ No ❑ Yes

Have you often been bothered by little interest or pleasure in doing things? ❑ No ❑ Yes

Do you have a health care proxy or advanced directive? ❑ No ❑ Yes

With whom do you live? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you …. ? \_\_\_ employed; type of employment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ homemaker

 \_\_\_ retired

 \_\_\_ full-time student: field of study \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ disabled: reason / year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ other; specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Mother** | **Father** | **Grandparent** | **Brother/Sister** | **Child** |
| Alzheimers |  |  |  |  |  |
| Asthma |  |  |  |  |  |
| Arthritis |  |  |  |  |  |
| Allergies |  |  |  |  |  |
| Alcoholism |  |  |  |  |  |
| Blood disorders |  |  |  |  |  |
| Cancer (specify type) |  |  |  |  |  |
| Depression/anxiety |  |  |  |  |  |
| Other mental illness |  |  |  |  |  |
| Diabetes |  |  |  |  |  |
| Heart disease |  |  |  |  |  |
| High blood pressure |  |  |  |  |  |
| Stomach/intestinal disease |  |  |  |  |  |
| Stroke |  |  |  |  |  |
| Skin disease |  |  |  |  |  |
| Thyroid problem  |  |  |  |  |  |
|  |  |  |  |  |  |
| Current Age(s)or Age at death |  |  |  |  |  |

**Other Health Care Providers**:

 **Do you have a…? Name and address**

Dentist ❑ No ❑ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Eye doctor ❑ No ❑ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Mental health ❑ No ❑ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 OB-GYN ❑ No ❑ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems**:

*(check any of the following that you have or have had in the past 6 months)*

|  |  |
| --- | --- |
| **Skin** | **Neurologic** |
|  | Rashes |  | Seizures |
|  | Change in a wart or mole |  | Paralysis |
| **Ear nose and throat** |  | Numbness or tingling |
|  | Nosebleeds |  | Dizziness |
|  | Allergies |  | Balance problems |
|  | Sinus problems | **Digestion** |
|  | Eye pain |  | Heartburn or reflux |
|  | Trouble seeing |  | Ulcer |
|  | Glaucoma |  | Nausea/vomiting |
|  | Double vision |  | Diarrhea |
|  | Ear pain |  | Constipation |
|  | Trouble hearing |  | Abdominal pain |
|  | Hoarseness |  | Black or bloody stool |
|  | Frequent sore throats |  | Liver or gallbladder trouble |
| **Respiratory** |  | Jaundice or yellow skin |
|  | Shortness of breath | **Urinary** |
|  | Wheezing |  | Pain on urination |
|  | Cough |  | Frequent urination |
|  | Coughing blood |  | Frequent urination at night |
| **Cardiovascular** |  | Inability to hold urine |
|  | Heart attack |  | Blood and urine |
|  | Chest pain |  | Kidney stones |
|  | Murmur | **Mental/emotional** |
|  | Irregular heartbeat/ palpitations |  | Anxiety |
|  | Swelling in ankles |  | Depression |
| **Endocrine** |  | Poor concentration |
|  | Heat intolerance |  | Poor memory |
|  | Cold intolerance | **General** |
|  | Excessive thirst |  | Poor sleep/insomnia |
|  | Excessive urination |  | Fatigue/low energy |
|  | Hair loss |  | Fever/chills |
|  | Change in weight |  | Poor appetite |
| **Muscles/joints/bones** | **Women only** |
|  | Joint pain |  | Change in periods |
|  | Muscle pain |  | Vaginal itching or discharge |
|  | Osteoporosis |  | Breast lumps |
|  | Joint swelling |  | Bleeding after menopause |
|  |  | **Men only** |
|  |  |  | Testicular swelling |
|  |  |  | Change in urinary stream |