Name (Last, First M.I.) _____

Date of Birth (Month/Day/Year) _____

Health History Questionnaire

UR MEDICINE

If you have completed sections 1-4 since your last birthday, please proceed to section 5. **Check all that apply.**

1. Medical History

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots/DVT
- ☐ Cancer
- ☐ CHF/Heart Failure
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ GERD/Heartburn/ Acid Reflux
- ☐ Heart Disease
- ☐ HIV/AIDS
- ☐ Hypertension/High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Palpitations/Racing Heart
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Other _____ _____

2. Surgical History

- ☐ No surgery
- ☐ Anesthesia Complications
- ☐ Appendectomy
- ☐ Breast surgery
- ☐ Colonoscopy
- ☐ Coronary Artery Bypass
- ☐ Coronary Artery Stent
- ☐ Eye Surgery
- ☐ Gallbladder Surgery (Cholecystectomy)
- ☐ Hernia repair Location _____
- ☐ Hysterectomy
- ☐ Joint Replacement _____
- ☐ Prostate Surgery
- ☐ Spine Surgery
- ☐ Organ Transplant
- ☐ Other _____ _____

3. Social History

Alcohol Use
☐ Yes ☐ No ☐ Never
☐ Wine
☐ Beer
☐ Liquor
Drinks per Week _____

Street Drug Use
☐ Yes ☐ No ☐ Never
☐ Marijuana
☐ Methamphetamines
☐ Cocaine
☐ Heroin
☐ Other

Tobacco Use
☐ Yes ☐ No ☐ Never
Type _____
☐ Current Smoker
Packs per day _____
☐ Former Smoker
Packs per day _____

Sexually Active
☐ Yes ☐ No
☐ Not Currently
Partners
Check all that apply
☐ Female ☐ Male
Birth Control / Protection
☐ Yes ☐ No
Method _____

4. Family Medical History Check all that apply.

☐ I have no family history
☐ I have unknown family history

Relationship	*Anemia*	*Anxiety*	*Arthritis*	*Asthma*	*Bleeding Disorder*	*Blood Clots /DVT*	*Cancer*	*CHF/Heart Failure*	*Depression*	*Diabetes*	*Emphysema/COPD*	*GERD/Heartburn/Acid Reflux*	*Heart Disease*	*HIV/AIDS*	*High Blood Pressure*	*Kidney Disease*	*Liver Disease*	*Palpitations/Racing Heart*	*Seizures*	*Stroke*	*Thyroid Problems*	*Other*
Father																						
Mother																						
Sibling																						
Maternal Grandmother																						
Maternal Grandfather																						
Paternal Grandmother																						
Paternal Grandfather																						
Other																						

see reverse side

Name (Last, First M.I.) _____

Date of Birth (Month/Day/Year) _____

Health History Questionnaire

If you have completed sections 1-4 since your last birthday, please proceed to section 5.

5. Primary Care Network

A. **ALLERGIES**

Allergies to Medications / Latex – Please Include Type of Reaction _____

_____

B. **MEDICATIONS**

Please list current medications. Include herbal and over the counter medications, dose and how many times a day you take the medication.

Medication	Dose	How many times do you take the med each day

C. **HEALTH CARE LEARNING** – This information will help us to provide you with medical information important to your health.

1. **What is your preferred language for learning medical information?**
   - ☐ English ☐ Japanese ☐ Vietnamese ☐ Arabic
   - ☐ Spanish ☐ Chinese ☐ Russian ☐ Hmong
   - ☐ American Sign Language ☐ Other (specify) _____

2. **How do you prefer to learn new medical information?**
   - ☐ Listening ☐ Reading ☐ Demonstration ☐ Pictures
   - ☐ Other (specify) _____

3. **Do any of the following affect how you learn new information?**
   - ☐ Difficulty Reading ☐ Eyesight ☐ Emotional Condition
   - ☐ Hearing ☐ Physical Condition ☐ Other_____