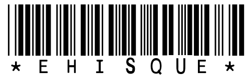
Regional Health



Patient
Last Name: ____________________

First Name: ____________________

Date of Birth: ____________________

Patient CSN #: ____________________

Health History Questionnaire

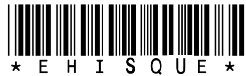
Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. **All questions contained in this questionnaire are optional and will be kept strictly confidential.**

How would you rate your general health?	❑ Excellent ❑ Good ❑ Fair ❑ Poor
Main reason for today's visit?	
Other concerns:	

PAST MEDICAL HISTORY

Please check all that apply:

HEENT	**RESPIRATORY**	**NEUROLOGIC**
❑ Allergies	❑ Asthma	❑ Epilepsy
❑ Blindness	❑ Bronchitis	❑ Head injury/Concussions: __________
❑ Cataracts	❑ COPD	❑ Headaches
❑ Chronic sinus problems	❑ Emphysema	❑ Migraines
❑ Glaucoma	❑ Pneumonia	❑ Seizures or Convulsions
❑ Hearing loss	❑ Tuberculosis	❑ Stroke
❑ Macular degeneration	❑ Other:	❑ Other:
❑ Other:	**GASTROINTESTINAL**	**HEMATOLOGY / CANCER**
CARDIOVASCULAR	❑ Appendicitis	❑ Anemia or Blood Disorders
❑ Atrial Fibrillation	❑ Celiac disease	❑ Blood clots
❑ Circulatory problems; Specify:	❑ Crohn's disease	❑ Breast cancer
❑ Congestive heart failure	❑ Eating disorder (anorexia/bulimia)	❑ Colon cancer
❑ Heart disease; Specify:	❑ Gallstones	❑ Prostate cancer
❑ Heart attack; When:	❑ Gastritis (stomach pain)	❑ Cancer; other:
❑ Heart murmur	❑ Hemorrhoids	❑ Transfusions
❑ High blood pressure/Hypertension	❑ Hepatitis	❑ Other:
❑ High cholesterol/Hyperlipidemia	❑ Hernias	**SKIN DISORDERS**
❑ Valvular heart disease	❑ Irritable bowel syndrome	❑ Eczema
❑ Other:	❑ Jaundice	❑ Psoriasis
GENITOURINARY	❑ Pancreatitis	❑ Skin cancer
❑ BPH	❑ Ulcerative colitis	❑ Other, Specify:
❑ Kidney disease	❑ Reflux (frequent indigestion)	**RHEUMATOLOGIC**
❑ Kidney stones	❑ Ulcers	❑ Fibromyalgia
❑ Frequent urinary tract infections	❑ Other:	❑ Gout
❑ Urinary incontinence	**ENDOCRINE**	❑ Lupus
❑ Other:	❑ Diabetes Mellitus Type 1; Age of onset:	❑ Osteoarthritis
PSYCHIATRIC	❑ Diabetes Mellitus Type 2; Age of onset:	❑ Rheumatic fever
❑ Alcohol problems	❑ Gestational Diabetes	❑ Rheumatoid arthritis
❑ Anxiety	❑ Hyperthyroidism	❑ Other:
❑ Depression	❑ Hypothyroidism	**SEXUALLY TRANSMITTED DISEASE**
❑ Drug problems/addictions	❑ Other:	❑ AIDS
❑ Other:	**MUSCULOSKELETAL**	❑ HIV
	❑ Arthritis	❑ Genital Herpes
	❑ Osteoporosis/Osteopenia	❑ Genital infections (Chlamydia/gonorrhea)
	❑ Physical therapy	❑ Genital warts (HPV)
	❑ Scoliosis	❑ Other:
	❑ Other:	



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Health History Questionnaire

PAST SURGICAL / HOSPITALIZATION HISTORY

Have you ever been hospitalized? ❑Yes ❑No

Surgery/Hospitalization	Reason	Year	Hospital

ARE YOU CURRENTLY EXPERIENCING ANY PROBLEMS WITH THE FOLLOWING (check all that apply)

CONSTITUTIONAL
- ❑ Exercise intolerance
- ❑ Fatigue
- ❑ Fever
- ❑ Night sweats
- ❑ Weight gain (______ lbs)
- ❑ Weight loss (______ lbs)

EYES
- ❑ Blurred vision
- ❑ Dry eyes
- ❑ Irritation
- ❑ Vision change

Date of last exam:

EARS / NOSE / MOUTH / THROAT
- ❑ Difficulty hearing
- ❑ Ear pain
- ❑ Ringing in ears
- ❑ Dizziness
- ❑ Nasal discharge
- ❑ Frequent nosebleeds
- ❑ Nose/Sinus problems
- ❑ Bleeding gums
- ❑ Dry mouth
- ❑ Sore throat
- ❑ Mouth ulcers
- ❑ Teeth problems
- ❑ Mouth breathing
- ❑ Frequent infections
- ❑ Hoarseness

CARDIOVASCULAR
- ❑ Arm pain on exertion
- ❑ Chest pain on exertion
- ❑ Chest heaviness/Pressure on exertion
- ❑ Irregular heartbeats (palpitations)
- ❑ Known heart murmur
- ❑ Light-headed on standing

CARDIOVASCULAR (continued)
- ❑ Shortness of breath when walking
- ❑ Shortness of breath when lying down
- ❑ Swelling (edema)

RESPIRATORY
- ❑ Cough
- ❑ Coughing up blood
- ❑ Wheezing
- ❑ Shortness of breath
- ❑ Sleep apnea
- ❑ Snoring

GASTROINTESTINAL
- ❑ Abdominal pain
- ❑ Black or tarry stools, or blood in stools:
- ❑ Change in appetite
- ❑ Constipation
- ❑ Frequent diarrhea
- ❑ Frequent indigestion
- ❑ Hemorrhoids
- ❑ Trouble swallowing
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Nausea

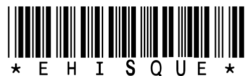
GENITOURINARY
- ❑ Blood in urine (hematuria)
- ❑ Difficulty urinating
- ❑ Incomplete emptying
- ❑ Increased urinary frequency
- ❑ Painful urination
- ❑ Urinary loss of control
- ❑ Wake in the night to go to the bathroom

Male Only:
- ❑ Pain or lump(s) in testicles
- ❑ Problems starting or stopping your urine stream
- ❑ Penile (penis) itching, burning or discharge
- ❑ Testicular problems

MUSCULOSKELETAL
- ❑ Back pain
- ❑ Joint pain
- ❑ Morning stiffness
- ❑ Muscle aches
- ❑ Muscle weakness

INTEGUMENTARY (skin)
- ❑ Changes in moles
- ❑ Dry skin
- ❑ Eczema
- ❑ Growth/Lesions
- ❑ Hair loss
- ❑ Itching
- ❑ Jaundice (yellow skin or eyes)
- ❑ Pigmentation changes
- ❑ Rash

NEUROLOGICAL
- ❑ Dizziness
- ❑ Frequent or severe headaches
- ❑ Loss of consciousness (fainting)
- ❑ Memory loss
- ❑ Migraines
- ❑ Numbness
- ❑ Restless legs
- ❑ Seizures or convulsions
- ❑ Speech problems
- ❑ Trauma, head
- ❑ Tremor
- ❑ Weakness



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Health History Questionnaire

ARE YOU CURRENTLY EXPERIENCING ANY PROBLEMS WITH THE FOLLOWING (continued)

PSYCHIATRIC	**ENDOCRINE**	**HEMATOLOGIC / LYMPHATIC**
❑ Alcohol overuse	❑ Goiter	❑ Easy bruising/Bleeding
❑ Anxiety/Stress	❑ Heat/Cold intolerance	❑ Swollen glands
❑ Depression	❑ High blood sugar	❑ Transfusions
❑ Do not feel safe in relationship	❑ Hormone therapy	**ALLERGIC / IMMUNOLOGIC**
❑ Hyperactivity	❑ Increased thirst/Hunger/Urination	❑ Frequent sneezing
❑ Mania	❑ Tremor	❑ Hives
❑ Sleep problems		❑ Itching
		❑ Runny nose
		❑ Sinus pressure

WOMEN ONLY

Last PAP Smear	Date	Abnormal?
Last Mammogram	Date	Abnormal?
Breast Exam	Date	Abnormal?

Age of first menstrual period:

Date of last menstrual period or age of menopause:

Birth control method used:

Number of pregnancies: __________ Births: __________ Miscarriages: ___________ Abortions: __________

❑ Cesarean sections If yes, then number:

❑ Vaginal itching, burning or discharge

❑ Painful intercourse

❑ Bleeding between periods

❑ Heavy periods

❑ Extreme menstrual pain

❑ Hot flashes

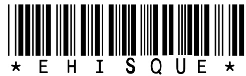
❑ Breast lump or nipple discharge

❑ Has the lump changed in size?

❑ Breast biopsies/Cyst/Aspirations

IMMUNIZATION HISTORY

Immunizations and most recent date:						
	❑ Tetanus	Date:	❑ Polio/IPV	Date:	❑ Tdap *tetanus and pertussis*	Date:
	❑ Hepatitis A	Date:	❑ Rabies	Date:	❑ Chickenpox	Date:
	❑ Hepatitis B	Date:	❑ Typhoid	Date:	❑ Flu Shot	Date:
	❑ Pneumonia / Pheumovax	Date:	❑ Yellow Fever	Date:	❑ Zostavax *Shingles*	Date:
	❑ Gardasil/HPV	Date:	❑ HIB	Date:	❑ MMR *Measles, Mumps, Rubella*	Date:
	❑ Meningococcus / Menactra	Date:	❑ Japanese Encephalitis	Date:		



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ALLERGIES

List anything that you are allergic to (medications, foods, bee sting, etc.) and how each affects you.

Allergy	Reaction

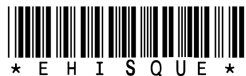
MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

Drug name	Strength	Frequency taken

FAMILY HEALTH HISTORY

Relation	Alive?	Age	Significant health problems
Grandmother *Maternal*	Y / N		❑ Alcoholism ❑ Arthritis ❑ Depression ❑ Cancer; type__________ ❑ Respiratory disease; type__________ ❑ Diabetes; type__________ ❑ Anemia ❑ Genetic disease ❑ Heart disease ❑ Hypertension ❑ Osteoporosis ❑ Stroke ❑ Suicide ❑ Kidney stones
Grandfather *Maternal*	Y / N		❑ Alcoholism ❑ Arthritis ❑ Depression ❑ Cancer; type__________ ❑ Respiratory disease; type__________ ❑ Diabetes; type__________ ❑ Anemia ❑ Genetic disease ❑ Heart disease ❑ Hypertension ❑ Osteoporosis ❑ Stroke ❑ Suicide ❑ Kidney stones
Grandmother *Paternal*	Y / N		❑ Alcoholism ❑ Arthritis ❑ Depression ❑ Cancer; type__________ ❑ Respiratory disease; type__________ ❑ Diabetes; type__________ ❑ Anemia ❑ Genetic disease ❑ Heart disease ❑ Hypertension ❑ Osteoporosis ❑ Stroke ❑ Suicide ❑ Kidney stones
Grandfather *Paternal*	Y / N		❑ Alcoholism ❑ Arthritis ❑ Depression ❑ Cancer; type__________ ❑ Respiratory disease; type__________ ❑ Diabetes; type__________ ❑ Anemia ❑ Genetic disease ❑ Heart disease ❑ Hypertension ❑ Osteoporosis ❑ Stroke ❑ Suicide ❑ Kidney stones
Father	Y / N		❑ Alcoholism ❑ Arthritis ❑ Depression ❑ Cancer; type__________ ❑ Respiratory disease; type__________ ❑ Diabetes; type__________ ❑ Anemia ❑ Genetic disease ❑ Heart disease ❑ Hypertension ❑ Osteoporosis ❑ Stroke ❑ Suicide ❑ Kidney stones
Mother	Y / N		❑ Alcoholism ❑ Arthritis ❑ Depression ❑ Cancer; type__________ ❑ Respiratory disease; type__________ ❑ Diabetes; type__________ ❑ Anemia ❑ Genetic disease ❑ Heart disease ❑ Hypertension ❑ Osteoporosis ❑ Stroke ❑ Suicide ❑ Kidney stones
Brother/Sister	Y / N		❑ Alcoholism ❑ Arthritis ❑ Depression ❑ Cancer; type__________ ❑ Respiratory disease; type__________ ❑ Diabetes; type__________ ❑ Anemia ❑ Genetic disease ❑ Heart disease ❑ Hypertension ❑ Osteoporosis ❑ Stroke ❑ Suicide ❑ Kidney stones



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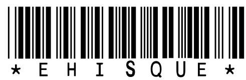
FAMILY HEALTH HISTORY (continued)			
Brother/Sister	Y / N		❑ Alcoholism ❑ Arthritis ❑ Depression ❑ Cancer; type___________ ❑ Respiratory disease; type___________ ❑ Diabetes; type___________ ❑ Anemia ❑ Genetic disease ❑ Heart disease ❑ Hypertension ❑ Osteoporosis ❑ Stroke ❑ Suicide ❑ Kidney stones
Other ___________	Y / N		❑ Alcoholism ❑ Arthritis ❑ Depression ❑ Cancer; type___________ ❑ Respiratory disease; type___________ ❑ Diabetes; type___________ ❑ Anemia ❑ Genetic disease ❑ Heart disease ❑ Hypertension ❑ Osteoporosis ❑ Stroke ❑ Suicide ❑ Kidney stones

SOCIAL HISTORY				
Occupation		**Spouse's Occupation**		
Education	❑ Less than 8th grade ❑ High school ❑ 2 year college ❑ 4 year college ❑ Post graduate			
Marital Status	❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Domestic partner			
Exercise Level	❑ None (No exercise)			
	❑ Occasional exercise (i.e., climb stairs, walk 3 blocks, golf)			
	❑ Moderate exercise (i.e., work or recreation, less than 4 times a week for 30 minutes)			
	❑ High level exercise (i.e., work or recreation 4 times a week for 30 minutes)			
Diet	Do you have a concern about your weight?		❑ Yes	❑ No
	If yes, are you on a physician prescribed medical diet?		❑ Yes	❑ No
	Number of meals you eat in an average day?			
	Salt intake	❑ High	❑ Moderate	❑ Low
	Fat intake	❑ High	❑ Moderate	❑ Low
Caffeine	❑ None	❑ Occasional	❑ Moderate	❑ Heavy
	Number of cups/cans a day?			
Alcohol	Do you drink alcohol?		❑ Yes	❑ No
	If so, how often? ❑ Occasionally ❑ less than 3 times a week ❑ more than 3 times a week			
	How many drinks a week?			
	Did you ever drink excessively?		❑ Yes	❑ No
	Are you prone to "binge" drinking?		❑ Yes	❑ No
	Do you drive after drinking?		❑ Yes	❑ No
Tobacco	Do you use tobacco?		❑ Yes	❑ No
	If not currently, did you ever use tobacco?		❑ Yes	❑ No
	_____ pack(s) a day	❑ Chew - _____ a day	❑ Pipe(s) - _____ a day	❑ Cigar(s) - _____ a day
	❑ Number of years ______	❑ Or year quit ______		
Drugs	Do you currently use recreational or street drugs?		❑ Yes	❑ No
	If yes, list:			
Personal Safety	Live alone?		❑ Yes	❑ No
	Live with Others?		❑ Yes	❑ No
	Guns present in home?		❑ Yes	❑ No
	Does anyone smoke in your home?		❑ Yes	❑ No
	Smoke alarm in home?		❑ Yes	❑ No
	Carbon monoxide alarm in home?		❑ Yes	❑ No
	Seatbelts used routinely?		❑ Yes	❑ No
	Sun screen used routinely?		❑ Yes	❑ No
	Advanced directive or living will?		❑ Yes	❑ No

Regional Health 

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SOCIAL HISTORY (continued)			
Personal Safety	Would you like information on advanced directive or living will?	❑ Yes	❑ No
	Durable medical power of attorney?	❑ Yes	❑ No
	Would you like information on durable medical power of attorney?	❑ Yes	❑ No
Other	Shoe size (Podiatry patients only):		
	Are you pregnant?	❑ Yes	❑ No
	Pets in home?	❑ Yes	❑ No
	Hobbies and recreational activities:		
	Travel outside of the United State ❑ Yes ❑ No When: Where:		
	Animal exposure?	❑ Yes	❑ No
	Tick bite?	❑ Yes	❑ No
	Sexual problems or concerns?	❑ Yes	❑ No
	Sexually active?	❑ Yes	❑ No
	Current sexual partner is?	❑ Male	❑ Female
	If sexually active do you use condoms?	❑ Yes	❑ No
	Interested in being screened for Sexually Transmitted Disease's ?	❑ Yes	❑ No

Please add any other information about your health that you would like your provider to know here:

HEALTH MAINTENANCE SCREENING TEST

Test		Date	Results	
Calcium Screen CT	❑ Yes ❑ No		❑ Normal	❑ Abnormal
Colonoscopy	❑ Yes ❑ No		❑ Normal	❑ Abnormal
Bone Density (Osteoporosis)	❑ Yes ❑ No		❑ Normal	❑ Abnormal
Exercise Stress Test	❑ Yes ❑ No		❑ Normal	❑ Abnormal
Lipid (Cholesterol)	❑ Yes ❑ No		❑ Normal	❑ Abnormal
Pulmonary Function Test	❑ Yes ❑ No		❑ Normal	❑ Abnormal
TB Skin Test	❑ Yes ❑ No		❑ Normal	❑ Abnormal
PSA	❑ Yes ❑ No		❑ Normal	❑ Abnormal
Prostate Exam	❑ Yes ❑ No		❑ Normal	❑ Abnormal
Chest X-ray	❑ Yes ❑ No		❑ Normal	❑ Abnormal
CT within the last 2 years	❑ Yes ❑ No		❑ Normal	❑ Abnormal
EKG	❑ Yes ❑ No		❑ Normal	❑ Abnormal

Patient or Surrogate Decision Maker: ____ Date: ____ Time: ____

Patient or Surrogate Decision Maker Name PRINTED: ____ Relationship to Patient: ____

Provider Name PRINTED: ____

Provider Signature: ____ Date: ____ Time: ____