



ANNUAL HEALTH HISTORY QUESTIONNAIRE

All information you provide is strictly confidential and will become part of your medical record. Please answer the questions to the best of your ability, especially any information that is new or has changed over the past year. You may leave any or all fields blank, but your provider may ask for the information in your office visit.

DEMOGRAPHICS

Last Name _____ First Name _____ Middle Initial _____

Date of Birth (mm/dd/yyyy) _____

Gender Female Male Transgender Other _____

Marital Status Single Married Partnered Separated Divorced Widowed

Occupation _____

Previous Source of Health Care _____

Date of Last Physical Exam _____

Is a record release signed? Yes No

Have you completed a Health Proxy or Living Will form? Yes No

MEDICAL CONDITIONS THAT HAVE BEEN DIAGNOSED

Acid Reflux/Heartburn Yes No Kidney Disease Yes No

Blood Pressure High Yes No Liver Disease/Hepatitis Yes No

Bowel Disease Yes No Lung Disease/Asthma Yes No

Cancer Yes No Stroke Yes No

Cholesterol Elevated Yes No Thyroid Disease Yes No

Diabetes Yes No Other _____

Heart Disease Yes No

CURRENT HEALTH PROBLEMS

Have you had a recent change in weight? Yes No

If yes, was it intentional? Yes No

Do you have difficulty sleeping? Yes No

Do you have fatigue? Yes No

Do you have pain? Yes No

Do you get up to urinate at night? Yes No

If yes, how many times each night? _____

Do you have difficulty with urination including pain, burning or blood in your urine? Yes No

Have you had kidney or bladder infections in the past year? Yes No

Do you have difficulty with your bowels? Yes No

Do you have difficulty breathing? Yes No

Do you have chest pain or pressure? Yes No

Do you have a cough? Yes No

Do you have mood changes? Yes No

Do you have frequent headaches? Yes No

Other _____

SURGERIES AND OTHER HOSPITALIZATIONS

Date	Reason	Name of Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IMMUNIZATIONS

	Date	Name of Facility
Tetanus/Diphtheria/Pertussis		
Pneumovax (Pneumonia)		
Zostavax (Shingles)		
Hepatitis B		
Other		

SCREENINGS

	Date	Name of Facility
Mammography		
Pap Test (Female or Male)		
Colonoscopy		
Bone Mass Density		
Anal Colposcopy (HRA)		
Rectal Exam		
Prostate Exam		
Other		

OTHER DOCTORS AND SPECIALISTS

	Date	Name of Facility
Dentist		
Eye Doctor		
Therapist/Counselor		
GYN		
Other		

PRESCRIPTIONS, OVER THE COUNTER MEDICATIONS AND HERBAL PRODUCTS USED

Name	Dose	Frequency

PRESCRIPTIONS, OVER THE COUNTER MEDICATIONS AND HERBAL PRODUCTS, Continued

Name	Dose	Frequency

ALLERGIES TO MEDICATIONS

Medication	Reaction

ALLERGIES TO FOOD AND ENVIRONMENTAL SOURCES

Source	Reaction

HEALTH HABITS AND PERSONAL SAFETY

Exercise What type of exercise do you do? _____

 How many times a week? Duration of workout _____

Diet Regular (Unrestricted) Vegetarian

Low Fat Vegan _____ # per day Soda

Low Salt Gluten Free _____ # per day

Low Carbohydrate Lactose Free Sports Drinks

 Number of meals average in a day _____

Caffeine Number of cups per day

 Coffee _____

 Tea _____

HEALTH HABITS AND PERSONAL SAFETY, Continued

Caffeine, cont'd

Soda _____

Energy Drink _____

Other _____

Alcohol Do you drink alcohol? Yes No

If yes, how many drinks per day or week? _____

Are you concerned about the amount you drink? Yes No

Have family or friends ever expressed concern about your drinking? Yes No

Tobacco Have you ever used tobacco? Yes No

If yes, how many years have you used tobacco? _____

If yes, year last used? _____

per day: Cigarettes _____ Cigars _____ Pipe _____ Chew _____

Drugs Have you ever used recreational or street drugs? Yes No

Have you ever misused prescription or non-prescription drugs? Yes No

Have you ever given yourself drugs with a needle that were not prescribed to you? Yes No

Would you like to meet with a provider to confidentially discuss your drug use? Yes No

Domestic Violence Have you ever felt unsafe or threatened by someone close to you? Yes No

Have you ever been a victim of verbal, psychological, or physical abuse? Yes No

Mental Health Have you ever been treated for: depression, anxiety, or other mental health problems? Yes No

Have you ever had a psychiatric hospitalization? Yes No

Have you ever attempted suicide? Yes No

Sexual Health Are you currently sexually active? Yes No

If yes, currently sexually active with: Men Women Both

Have you ever had a sexually transmitted infection? Yes No

HEALTH HABITS AND PERSONAL SAFETY, Continued

If yes, please list date and type of infection _____

Would you like to speak with a counselor about your risk of HIV/AIDS? Yes No

Do you think of yourself as: Straight or heterosexual
 Lesbian, gay, or homosexual
 Bisexual Something else Don't know

Women's Health

Age at onset of menstruation _____ Age at onset of menopause _____

Date of last period _____ Period every ____ days for ____ days

Bleeding/spotting between periods? Yes No

Bleeding/spotting since menopause? Yes No

Flow Light Moderate Heavy

Cramping? Yes No

Are you currently trying to get pregnant? Yes No

If no, what is your birth control method? _____

Are you pregnant? Yes No

Are you breastfeeding? Yes No

Men's Health

Do you have pain, burning, or discharge from your penis? Yes No

Do you have difficulty with erection or ejaculation? Yes No

Do you have testicle pain or swelling? Yes No

Safety

Are you exposed to hazardous materials or situations at work? Yes No

Do you regularly wear a seatbelt? Yes No

Are there guns in the house? Yes No

FAMILY HEALTH HISTORY

Mother

Father

Siblings

Adopted – History Unknown

Children

Thank You for Completing this Form

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