Outer Cape
HEALTH SERVICES

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. ***Please complete in BLACK ink only.***

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/Diptheria/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)
❑ Low Fat
❑ Low Salt
❑ Low Carbohydrate
❑ Vegetarian
❑ Vegan
❑ Gluten Free
❑ Lactose Free

_____ # per day Soda

_____ # per day 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