# 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. You may leave any or all fields blank, but your provider may ask for the information in your office visit. ***Please complete in <u>BLACK ink only</u>.***

***Date Completed:*** ______________

## DEMOGRAPHICS

Last Name ______________ First Name ______________ Middle Initial ____

Date of Birth (mm/dd/yyyy) ______________

Primary Care Provider Gender Preference
- Male
- Female
- No Preference

______________

Previous Source of Health Care: (Primary Care Provider Name, Facility, Phone Number)

______________________________________________

Date of Last Visit? ______________

Have you completed and signed a medical record release form for your primary care provider and specialists, including mental health providers? ☐ Yes ☐ No

If not, please complete and sign release forms.

**MEDICAL CONDITIONS: Circle any of the following conditions you have had.**

| | | | | | |
|---|---|---|---|---|---|
| Allergies or Asthma | | Cholesterol (high) | | High Blood Pressure | |
| Acid Reflux/Heartburn | | Congestive Heart Failure | | Lung Disease | |
| Alcoholism | | Depression and/or Anxiety | | Stroke | |
| Anemia | | Diabetes | | Thyroid Disease | |
| Arthritis | | Drug or Alcohol Use Disorder | | Other (list): | |
| Breast lumps/cysts | | Heart Disease | | | |
| Cancer (tumors) | | Hepatitis | | | |

**SURGERIES AND OTHER HOSPITALIZATIONS**

| Date | Type of surgery / reason | Name of hospital |
|---|---|---|
| | | |
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| | | |
| | | |

**RECENT SCREENINGS (eg, last mammography, pap test, colonoscopy – Please request prior records from the facilities where these were performed)**

| |
|---|
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| |

**OTHER DOCTORS AND SPECIALISTS (Patient Care Team)**

| Specialist Type | Specialist/ Facility | Specialist Type | Specialist/ Facility |
|---|---|---|---|
| Dental | | Gyn/OB | |
| Eye Doctor | | Podiatry | |
| Dermatology | | Other | |
| Psychiatry (prescriber) | | Other | |
| Therapist/Counselor | | Other | |

## PRESCRIPTIONS, OVER THE COUNTER MEDICATIONS AND HERBAL PRODUCTS

| Name | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
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| | | |
| | | |

## ALLERGIES TO MEDICATIONS

| Medication | Reaction |
|---|---|
| | |
| | |
| | |

## ALLERGIES TO FOOD AND ENVIRONMENTAL SOURCES

| Source | Reaction |
|---|---|
| | |
| | |

## SOCIAL HISTORY/HEALTH HABITS AND PERSONAL SAFETY

**Occupation:**

**Living Situation:**

**Marital Status** ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

**Smoking**

Have you ever used tobacco?

☐ Current smoker ☐ Former smoker ☐ Never smoke

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

If yes, year last used? ☐

Amount per day: Cigarettes ☐ Cigars ☐ Vape/Pipe ☐ Chew ☐

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**Alcohol**

How often did you have a drink containing alcohol in the past year?

☐ Never ☐ Monthly or less ☐ Two to four times a month
☐ Two to three times per week ☐ Four or more times a week

How many drinks containing alcohol did you have on a typical day when you were drinking in the past year? (1 drink = 12 oz. beer, 4 oz wine, 1.5 oz spirits)

☐ 0 drinks ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

How often did you have six or more drinks on one occasion in the past year

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

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**Sexual Health**

When you were last tested for sexually transmitted infections (STIs)? ☐

Have you had any type of sexual contact since the last time you were tested for STIs? ☐ Yes ☐ No

If you have a concern about sexually transmitted infections that you need addressed more urgently, please contact our Sexual Health staff at 774-538-3350

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**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 was not prescribed to you? ☐ Yes ☐ No

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

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**Domestic Violence**

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

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

Do you feel safe at home? ☐ Yes ☐ No

**Diet** List any dietary restrictions:

**Exercise** What type of exercise do you do?

How many times a week? Duration of workout

**Caffeine** Number of cups/drinks per day?

Coffee Soda

Tea Energy Drink

**Mental Health** Have you ever had a psychiatric hospitalization? ❑ Yes ❑ No

Have you ever attempted suicide? ❑ Yes ❑ No

**Food Security** In the past 12 months, have you been worried that food would run out before you had money to buy more.

❑ Yes ❑ Sometimes ❑ Never

**Women's Health** Are you pregnant? ❑ Yes ❑ No

Date of last period Period every days for days

Are you currently trying to get pregnant? ❑ Yes ❑ No

If no, what is your birth control method?

## FAMILY MEDICAL HISTORY

❑ Are you **Adopted?** – History Unknown ❑ Yes ❑ No

| Family Member | Age | Alive? | If Deceased, cause | Age at Death |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |
| Siblings(s) | | | | |
| | | | | |
| Children | | | | |
| | | | | |
| Other | | | | |
| | | | | |

**Thank You for Completing this Form**