Today's Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential.

Name *(Last, First, M.I.):* ☐ M ☐ F ☐ Transgender	**DOB:**
Email address:	**Mobile phone :**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Dating	
Previous or referring medical provider:	**Date of last physical exam:**
Current issue(s) of concern:	**Treatment goals:** 1) 2) 3)

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Healthy ☐ Frequent colds ☐ Ear infections ☐ Asthma ☐ Digestive issues ☐ Other:		
Immunizations and dates:	☐.Tetanus/Diphtheria/Pertussis	☐ Pneumonia
	☐ Hepatitis B	☐ Shingles
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*
	☐ Chickenpox	☐ Prefer not to vaccinate

List any medical problems that other medical provider have diagnosed and year of diagnosis

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers (or attach current list)		
Name of Drug/Strength (i.e. Lipitor 20mg tab)	Prescribed/Recommended by	Frequency Taken
Allergies to medications		
Name of Drug	Reaction You Had/Severity	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ No exercise					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (work or recreation, approx. 2x/week for at least 30 min.)					
	☐ Regular vigorous exercise (work or recreation, 3 or more x/week for at least 30 mins.)					
Diet	Are you currently trying to lose weight?				☐ Yes	☐ No
	Are you following a special diet? (more details in diet section on page 4)				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank sugar/carb intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Soda		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?		How many drinks per week?			
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you now or have you ever used tobacco?				☐ Yes	☐ No
	☐ Cigarettes: # cigs/day:		☐ E-cigs: #/day:	☐ Chew: #/day:	☐ Cigar: #/day:	
	☐ Age started:	☐ # of years of use:		☐ Year quit:		
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

Sex	Are you sexually active? Are you in a monogamous relationship? Current partner(s) is (are): ☐ Male ☐ Female ☐ Both ☐ N/A	☐ Yes ☐ Yes	☐ No ☐ No
	Are you trying for a pregnancy?	☐ Yes	☐ No
	Please list any contraceptive or "safer sex" methods used (i.e. condoms, IUD, etc):		
	Sexual partners have included: ☐ Men ☐ Women ☐ Both		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Any history of sexually transmitted infection? If so, list below:	☐ Yes	☐ No
Personal Safety	Do you live alone? Number of people living in your home (including yourself): _____	☐ Yes	☐ No
	Do you feel safe in your home?	☐ Yes	☐ No
	Are your friends and family generally supportive?	☐ Yes	☐ No
	Have you experienced frequent falls?	☐ Yes	☐ No
	Any history of verbally threatening behavior, physical or sexual abuse? Would you like to discuss this issue with your provider?	☐ Yes ☐ Yes	☐ No ☐ No
	Do you have an Advance Directive or Living Will? Would you like information on the preparation of these?	☐ Yes ☐ Yes	☐ No ☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father	☐ Alive ☐ Deceased		**Children**	☐ M ☐ F	
Mother	☐ Alive ☐ Deceased			☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*	☐ Alive ☐ Deceased	
	☐ M ☐ F		**Grandfather** *Maternal*	☐ Alive ☐ Deceased	
	☐ M ☐ F		**Grandmother** *Paternal*	☐ Alive ☐ Deceased	
	☐ M ☐ F		**Grandfather** *Paternal*	☐ Alive ☐ Deceased	

MENTAL HEALTH

Are you generally happy with your life currently?	☐ Yes	☐ No
Is stress a major problem for you?	☐ Yes	☐ No
Do you frequently feel depressed?	☐ Yes	☐ No
Do you frequently feel anxious?	☐ Yes	☐ No
Any history of anorexia, bulimia or other disordered eating?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever been to a counselor or psychologist?	☐ Yes	☐ No
Do you frequently have trouble sleeping?	☐ Yes	☐ No
Are you interested in working with a therapist or life coach?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in: (see below)
☐ Head/Neck	☐ Back	☐ Weight
☐ Eyes/Ears	☐ Digestion	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowels	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

DIET

Please list foods typically consumed for the following meals

☐ Breakfast Time of meal:	☐ Lunch Time of meal:	☐ Dinner Time of meal:
Which of the following diets do you follow? Check all that apply: ☐ Omnivore (no restrictions) ☐ Vegetarian (eat eggs & milk products) ☐ Vegan (no eggs or milk products) ☐ Pescatarian (no meat other than fish) ☐ Gluten-free (no gluten) ☐ Paleo (minimal grains or dairy) ☐ FODMAPS (specific carb restriction) ☐ GAPS (gut & psychology syndrome) ☐ Other:	☐ Food sensitivities (list below with reaction):	☐ Snacks: ☐ Desserts:

WOMEN/TRANS MEN ONLY

Age at onset of menstruation:	Date of last menstruation:	Period every _____ days	
Date of last pap smear?	Pap smear done by:		
Any abnormal pap smears? ☐ Yes ☐ No			
Heavy periods, irregularity, spotting, pain, or discharge?		☐ Yes	☐ No
Number of pregnancies: _____	Number of live births: _____	Number of miscarriages: _____	Number of abortions: _____
Are you pregnant or breastfeeding?		☐ Yes	☐ No
Have you had a hysterectomy?		☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?		☐ Yes	☐ No
Any blood in your urine?		☐ Yes	☐ No
Any problems with control of urination?		☐ Yes	☐ No
Any hot flashes or sweating at night?		☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?		☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?		☐ Yes	☐ No
Would you like your breasts examined at your upcoming medical visit?		☐ Yes	☐ No
Is there anything else you would like to discuss privately with your medical provider?			

MEN/TRANS WOMEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No
Is there anything else you would like to discuss privately with your medical provider?	☐ Yes	☐ No