Providence Medical Group / Mill Plain
315 SE Stonemill Drive, Ste 102 - Vancouver, WA 98684
Phone: 360-816-2700 - Fax: 360-816-2710

Health History Questionnaire

Date of visit: _____

Full Name: _____ Birthdate: _____ Age: _____ Sex: Male Female

Present symptoms / what brings you in today?: 1._____ 2. _____ 3. _____

Current Meds: Name and Strength	How many times do you take per day?	How long have you taken this medication?

Known Drug Allergies or Sensitivities:

Name of Medication /Item:	Reaction:

Past Medical History and Current Problems:

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

Are ***you currently or have you experienced*** any of the following symptoms? **Please circle if yes**:

Environmental Allergies
Anemia
Anxiety
Arthritis
Asthma
Blood transfusions
Cancer
Cataracts
Congestive Heart Failure
Clotting disorders of blood
COPD
Depression
Diabetes
Emphysema
Gastrointestinal reflux (GERD)
Glaucoma
Heart Murmur
HIV/AIDS
High blood pressure
Kidney disorder / disease
Meningitis
Heart Attack
Nerve/muscle disease
Osteoporosis
Seizure disorder
Sickle cell anemia
Stroke
Substance abuse
Thyroid disease
Tuberculosis
Ulcer
Fevers / chills / night sweats
Fatigue
Loss of appetite
Weight gain / loss more than 15#
Blurred vision / double vision
Eye irritation / discharge
Eye pain / redness / dryness
Vision loss
Light / noise sensitivity
Ear pain / discharge
Ringing in the ears / Hearing loss
Sneezing / nasal congestion
Frequent sore throat
Nosebleeds
Throat hoarseness
Difficulty swallowing
Chest pain
Sudden changes or irregular heart beat
Fainting or dizziness
Shortness of breath
Shortness of breath w/ exercise
Swelling in legs or feet
Cough / wheezing
Coughing up blood
Nausea / vomiting
Persistent diarrhea
Increasing constipation
Heartburn
Changes in bowel habits
Pain after eating
General abdominal pain
Vomiting blood
Blood in stools / black stools
Pain / burning with urination
Vaginal discharge
Urinary frequency / urgency
Frequent nighttime urination
Inability to hold urine
Sexual difficulties / decreased desire
Genital sores
Back / neck pain
Muscle pain / cramps / weakness
Morning muscle stiffness
Skin rash / redness / hives / bumps
Headache
Memory loss
Trouble sleeping
Suicidal or homicidal thoughts
Hallucinations / paranoia
Cold / heat intolerance
Frequent or difficult urination
Excessive or easy bruising / bleeding
Enlarged lymph nodes

List all Surgeries or Major Procedures:	
Year	Reason / Facility

PLEASE COMPLETE BOTH SIDES OF FORM

Family history: please indicate the current status of your immediate family members ***PLEASE COMPLETE SECTION***

	Alive	Deceased	Age (now/at death)	Comments/Medical Problems
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Sister(s) #___	_____	_____	_____	_____
Brother(s) #__	_____	_____	_____	_____

Family Medical History (circle if your family has a history of the following):

Arthritis	Hearing Loss	Miscarriages / Stillbirths
Asthma	Heart disease	Stroke
Birth defects	High blood pressure	Substance abuse
Cancer	High cholesterol	Vision loss
COPD	Kidney disease	Other: _____
Depression	Learning disabilities	Other: _____
Diabetes	Mental illness	
Early death	Mental retardation	

Personal Social History: Student / Retired / Unemployed /Employed- Occupation: _____

Years of Education / Highest Degree: _____ Employer:_____

Do you have any children? Name and age:_____

Marital Status: Married/Single/In relationship/Widowed/Divorced/Separated/Domestic partner/ Other: _____

Other adults currently living in the same home? Name, age, relation: _____

Tobacco use: Never / Current /Quit, date: _____ ____packs per day for _____ years Interested in quitting: Y N

Other tobacco use: Pipe/Cigar/Snuff/Chew _____ per day / week / month / year for ____ years Quit, date: _____

Alcohol use: Current/Occasional-Social/Quit, date: _____ Number of drinks per week / month / year:_____

Are you or anyone else concerned about your alcohol use? Y N

Drug use: Never/ Current- daily/ Social Settings Only Type(s): _____ #times per week / month / year:_____

Sexual Activity: Have you had sex? Y N Number of partners in lifetime: _____ Birth control method: _____

Do you prefer to have sex with men, women or both? History of sexually transmitted disease? N Y, type: _____

List all Overnight or Inpatient Hospitalizations:

Year	Reason

Caffeine intake: ___none ___coffee/tea: 8oz cups/day_____ __soda: # per day_____ ____chocolate: oz per day _____

Weight: Are you satisfied with your current weight? Y N

Diet: How would you rate your diet? Good Fair Poor Do you take supplements or vitamins? Y N (on med list above?)

Exercise: Do you exercise regularly? Y N What kind: _____ How long (minutes)? _____ How often: _____

Safety: Wear seatbelt consistently? Y N Do you have a gun in your home? Y N If yes- are they stored safely? Y N

Is violence at home a concern? Y N Has this ever been a concern? Y N Please explain: _____

Immunizations and Screenings: please list actual or approximate (month/year) dates

Last physical: _____ Last colonoscopy: _____ Shingles shot: _____

Pneumovax (pneumonia vaccine): _____ Flu shot: _____ Tetanus shot: _____

WOMEN ONLY:

When was your last PAP test? _____ History of any abnormal PAPs? Yes or No Treatment? _____

When was your last mammogram? _____ When was your last bone density screening? _____

# of Pregnancies _____ # of Deliveries _____ # of Abortions_____ # of Miscarriages _____

1st day of last period _____ Age at 1st period _____ Regular or irregular Average length (days) _____

Do you have any concerns about your periods? No Yes; explain: _____

Do you have any concerns about menopause? No Yes; explain: _____