Health History Questionnaire

PROVIDENCE
Medical Group
The Plaza

Family Medicine
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Phone: 503.215.6405 Fax: 503.215.6429

Date of Visit: _____

Name: _____ Sex: ***M F***
Last First Middle Initial Maiden

Age: _____ ***Date of Birth:*** _____ / _____ / _____ ***Marital Status:*** M S W Div Sep Dom Partner

Social History: ❑ Student ❑ Retired Occupation: _____

Who currently lives with you? Name and relation: _____

_____

Children names and years of birth: _____

Present Symptoms / Why are you here today?: _____

_____

_____

Other physicians you are currently under the care of:	***List allergies or sensitivities you have to medications:***
	Drug ***Reaction***
_____	_____
_____	_____
_____	_____

List of medications & how you take them: (Please include all medications including over-the-counter, topicals & vitamins)

NAME OF DRUG	***DOSE*** (include strength & # per day)	***How long have you taken this medication?***

List all Previous Immunizations or Screenings & Date:

❑ Pneumovax Date: _____
❑ Tetanus Date: _____
❑ Polio Date: _____
❑ Flu Date: _____
❑ Measles Date: _____
❑ Rubella Date: _____
❑ Hepatitis B Date: _____
❑ Hepatitis A Date: _____
❑ Pertussis Date: _____

Please list all operations & hospitalizations with their appropriate year

ILLNESS / INJURY	***YEAR***	***ILLNESS / INJURY***	***YEAR***
1. _____		4. _____	
2. _____		5. _____	
3. _____		6. _____	

Do you or have you ever used tobacco? What _____ How much _____ How long _____ Yr quit _____
Do you use alcohol? What _____ How much _____ How long _____ Yr quit _____
Do you use recreational drugs? What _____ How much _____ How long _____ Yr quit _____
Do you use caffeine? What _____ How much _____ How long _____ Yr quit _____
Are you sexually active? (Circle one) Heterosexual Homosexual Bisexual
Are you generally satisfied with your level of sexuality? _____
If you use contraceptives, what type? _____
Do you get enough sleep at night? ❑ Yes ❑ No Do you wake up feeling rested? ❑ Yes ❑ No

Name: _____ ***Date of Birth:*** _____ / _____ / _____ ***Date:*** _____

OB/GYN HISTORY (for women only)

Pregnancy history, enter number of:

Times pregnant	_____	Premature births	_____	Miscarriages	_____
Abortions	_____	Live births	_____	Living children	_____
Have you ever had: Abnormal PAP	_____	Breast problems	_____	Breast cancer	_____

FAMILY HISTORY	Current Age	Died at Age	Diseases / Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brother / Sister	_____	_____	_____
Brother / Sister	_____	_____	_____
Brother / Sister	_____	_____	_____

MEDICAL HISTORY (check if you or your family have ever had the following illness)

You	***Your Family***		***You***	***Your Family***		***You***	***Your Family***	
❑	❑	Alcoholism	❑	❑	Glaucoma	❑	❑	Phlebitis, clot in leg
❑	❑	Anemia	❑	❑	Heart disease	❑	❑	Rheumatic fever
❑	❑	Asthma	❑	❑	Headaches	❑	❑	Sexually transmitted disease
❑	❑	Cancer	❑	❑	High blood pressure	❑	❑	Stroke
❑	❑	Diabetes	❑	❑	Kidney / bladder problem	❑	❑	Suicide attempt
❑	❑	Drug use	❑	❑	Leukemia	❑	❑	Thyroid disease
❑	❑	Depression	❑	❑	Liver disease	❑	❑	Ulcer in stomach / intestine
❑	❑	Eczema	❑	❑	Lung disease	❑	❑	Uncontrolled bleeding
❑	❑	Epilepsy	❑	❑	Tuberculosis	❑	❑	Other
❑	❑	Eye problem	❑	❑	Psychiatric condition			_____

DO YOU HAVE AN ADVANCED DIRECTIVE? _____

CURRENTLY ARE YOU EXPERIENCING SYMPTOMS / CONCERNS:

GENERAL
- ❑ Recent weight gain
- ❑ Recent weight loss
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever

NERVOUS SYSTEM
- ❑ Sensitivity or pain of hands / feet
- ❑ Loss of consciousness
- ❑ Dizziness
- ❑ Memory loss
- ❑ Headaches
- ❑ Muscle spasms

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Feels like something is in the eye
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

NOSE
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness

MOUTH
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing

NECK
- ❑ Swollen glands
- ❑ Tender glands

HEART & LUNGS
- ❑ Sudden changes in heart beat
- ❑ Difficulty in breathing at night
- ❑ Shortness of breath
- ❑ Swollen legs or feet
- ❑ Irregular heart beat
- ❑ High blood pressure
- ❑ Coughing up blood
- ❑ Pain in chest
- ❑ Heart murmurs
- ❑ Cough
- ❑ Wheezing
- ❑ Night sweats

STOMACH & INTESTINES
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Yellow jaundice
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn
- ❑ Nausea

KIDNEY / URINE / BLADDER
- ❑ Pain or burning on urination
- ❑ Discharge from pelvis / vagina
- ❑ Getting up at night to pass urine
- ❑ Cloudy, “smoky” urine
- ❑ Frequent urination
- ❑ Difficult urination
- ❑ Vaginal dryness
- ❑ Sexual difficulties
- ❑ Prostate trouble
- ❑ Blood in urine
- ❑ Pus in urine
- ❑ Rash / ulcers

BLOOD
- ❑ Bleeding tendency
- ❑ Anemia

SKIN
- ❑ Color changes of hands / feet in the cold
- ❑ Sun sensitive (sun allergy)
- ❑ Nodules / bumps
- ❑ Easy bruising
- ❑ Hair loss
- ❑ Tightness
- ❑ Redness
- ❑ Rash
- ❑ Hives

MUSCLES / JOINTS / BONES
- ❑ Muscle tenderness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling
- ❑ Morning stiffness