

INITIAL HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (<i>Last, First, M.I.</i>):	Age:	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Number of children:	Age Range of Children:	
Previous or referring doctor:		
Do you have another primary care provider?		
Reason for visit:		

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed

List all medications and supplements taken regularly

Name the Drug or Supplement	Dose (strength and frequency)	Prescribed by: (write "Self" if self-prescribed)

GENERAL WELL-BEING

Sleep Quality	Average number of hours of sleep:
Do you wake feeling rested?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have trouble falling asleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wake during the night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, do you have trouble falling back asleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rate your current energy on a scale of 1-10 (10=highest):	
Rate your current stress level on a scale of 1-10 (10 =highest):	
What do you do to manage your stress?	
Do you have a spiritual practice? What?	

Name:		DOB:		Date:	
HEALTH HABITS AND PERSONAL SAFETY					
Exercise	In a typical week, how many times do you do the following kinds of exercise for more than 15 minutes during your free time....				
	<input type="checkbox"/> Sedentary (No exercise)				
	_____ times per week	Mild exercise (climb stairs, walk 3 blocks, yogs, golf)			
	_____ times per week	Moderate exercise (fast walking, tennis, dancing)			
	_____ times per week	Vigorous exercise (running, jogging, soccer, long distance bicycling)			
Diet	Do you follow a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, specify:		
	Do you avoid any foods? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, specify:		
	How much water do you drink per day?		Is it filtered water? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes		
	How many of the last SEVEN DAYS have you followed a healthful eating plan? (1-7)				
	On average, over the past month, how many DAYS PER WEEK have you followed a healthful eating plan? 0 1 2 3 4 5 6 7				
	On how many of the last SEVEN DAYS did you eat five or more servings of fruits and vegetables? 0 1 2 3 4 5 6 7				
	On how many of the last SEVEN DAYS did you eat high fat foods such as red meat or full fat dairy? 0 1 2 3 4 5 6 7				
	Please list the typical foods you eat for:				
	Breakfast:				
	Lunch:				
	Dinner:				
Snacks:					
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola/Soda	
	# of cups/cans per day?				
Drugs	Do you currently use recreational or street drugs?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex	Are you currently sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No		Gender of partner(s):	<input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Both
	If yes, are you trying for a pregnancy?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	If you are not trying for a pregnancy, list contraceptive or barrier method used:				
	Have you been sexually active in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No		Gender of past partner(s):	<input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Both
	Any problems or concern with sexual function or desire?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal Safety	Do you live alone?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have frequent falls?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have vision or hearing loss?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you wear your seat belt? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you wear your helmet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is the battery current in your smoke detector?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Would you like information on the preparation of these?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				<input type="checkbox"/> Yes <input type="checkbox"/> No

Name:		DOB:		Date:	
Screening Exams: Please indicate the date of your last exam and whether it was normal. Skip sections that don't apply to your age or health status.				Doctor's Use Only	
EXAM		DATE	RESULT	COMMENTS	DATES OF REVIEW:
Weight	Current Weight			BMI >25 overweight; >30 obese; >40 morbid obese	
	Lowest Adult Weight				
	Highest Adult Weight				
CVD Risk	Cholesterol		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Every 5 yrs for M > 35 yo; F > 45 yo	
		Total:	HDL: LDL:		
	Previous heart attack or stroke?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Framingham Risk:	
Diabetes	Fasting Blood Sugar Screening?		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Screen: 45 y.o & BMI > 25; HTN; ↑Lipids.	
	Gestational Diabetes?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	HbA1c				
	Average fasting glucose			HOMA: IS= BR=	
	Eye Exam		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Yearly	
	Microalbumin/Creatinine		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Yearly	
Colon Ca	Colonoscopy		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Every 10 years > 50 yo	
	Hemoccult/Blood in stool		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Yearly > 50 yo	
Women	Pelvic/Pap Test		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Every 1-3 years	
	Mammogram		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Every 1-2 years > 40	
	STI screening (GC/Chlam)		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	High risk < 25 yo	
Men	PSA		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
	Digital Rectal Exam		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
	STI screening (GC/Chlam)		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
HIV Status			<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Offer test if u/k status	
Ophthalmologist			<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
Dental			<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
Dermatology			<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
DEXA / Osteoporosis			<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
Depressi on (PHQ-2)	In the past 2 wks, have you been or had:				
	<i>Little interest or pleasure in doing things?</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<i>Feeling down, depressed or hopeless?</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Alcohol/Drug Use/Tobacco (CAGE)	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes, what kind? How many drinks per week?				
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Have you felt you ought to cut down?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Do people annoy you by criticizing your use?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Have you felt bad/guilty about your use?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Tobacco	Have you ever had to have an eye-opener?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Amount per day				
<input type="checkbox"/> # of years: OR <input type="checkbox"/> Year Quit:					
Advanced Directives?			<input type="checkbox"/> Yes <input type="checkbox"/> No		

Name:	DOB:	Date:
MENTAL HEALTH		

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you intentionally harmed yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting others?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel you have an adequate support system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently seeing a counselor? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, who?	

WOMEN ONLY		
Age at onset of menstruation:		
First day of last menstrual period: ____/____/____	Number of days of flow:	
Period every ____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been instructed on breast self-exams?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MEN ONLY		
Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times ____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been instructed on testicular self-exams?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Name:	DOB:	Date:
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Review of systems: Mark "C" for current problems; Mark "P" for past problems and indicate dates.

Past or Current?	Allergic/Immunologic	Past or Current?	Ears, Nose, Mouth, Throat (cont.)	Past or Current?	Hematological
	Arthritic flare-up		Epistaxis (nosebleeds)		Anemia
	Hay fever symptoms		Hoarseness		Bruise Easily
	Cardiovascular		Hypoglycemia		Musculoskeletal
	Ankle swelling		Ringing in ear		Back pain (chronic)
	Chest pain		Sinus problem		Foot pain
	Elevated blood pressure		Sore throat		Gout attack
	Fatigue		Eyes		Leg pain
	Irregular heartbeat		Blurred Vision		Neck pain
	Murmur (heart)		Loss of vision		Neurological
	Palpitations		Pain or soreness in or about the eyes		Difficulty concentrating
	Shortness of breath at rest		Gastrointestinal		Dizziness
	Shortness of breath in the night		Abdominal pain		Headache
	Shortness of breath with exercise		Blood in stool		Numbness
	Syncope (fainting)		Constipation		Seizures
	Varicose veins		Diarrhea		Tingling
	Dermatologic (Skin)		Heartburn		Tremors
	Eczema		Hemorrhoids		Psychiatric
	Hives		Loss of appetite		Anxiety
	Pruritis (itching)		Melena (dark, tarry stools)		Depression
	Psoriatic flare-up		Nausea		Insomnia
	Rash		Swallowing difficulty		Memory Loss
	Endocrine		Vomiting		Mood changes
	Cold intolerance		Weight gain		Respiratory
	Dry Skin		Weight loss, unintentional		Asthma
	Excess hair growth		Yellowing of skin		Cough
	Extreme thirst		Genitourinary		Wheezing
	Hyperglycemia		Discharge (from urethra)		Shortness of breath
	Thyroid disease		Painful urination		
	Unusual fatigue		Urinary difficulty		Other? Please explain:
	Ears, Nose, Mouth, Throat		Urinary incontinence		
	Cough, chronic		Urinary output low		
	Difficulty with hearing		Urinating frequently at night		
	Ear infection				