Confidential Health History Questionnaire

To be completed by the patient.

NAME: _____ DATE OF BIRTH: _____ AGE: _____ DATE: _____

PAST MEDICAL HISTORY:

LIST ANY SURGERY YOU HAVE HAD, SUCH AS: TONSILS, APPENDIX, DENTAL, GALLBLADDER

DATE	SURGERY	REASON

LIST ANY OTHER HOSPITALIZATIONS:

DATE	REASON FOR HOSPITALIZATION

LIST ANY SERIOUS ACCIDENTS OR INJURIES:

DATE:	NATURE OF THE PROBLEM

READ THE FOLLOWING AND (√) ANY THAT YOU HAVE HAD:

- ☐ Stroke
- ☐ Muscle Disease or Weakness
- ☐ Chronic Back Disease
- ☐ Arthritis or Gout
- ☐ Bone or Joint Disease
- ☐ Bladder or Kidney Infections
- ☐ Kidney Disease or Stones
- ☐ Herpes / Chlamydia
- ☐ Meningitis or Polio
- ☐ Gonorrhea or Syphilis
- ☐ Recurrent Bronchitis
- ☐ Recurrent Pneumonia
- ☐ Asthma
- ☐ Tuberculosis (TB)
- ☐ Ulcer Disease
- ☐ Chronic Bowel / Colon Disease
- ☐ Pancreatitis
- ☐ Gallbladder Disease
- ☐ Hepatitis and/or Cirrhosis
- ☐ Drug Abuse or Alcoholism
- ☐ Severe Depression
- ☐ Nervous Breakdown
- ☐ Bleeding Disorder
- ☐ Sickle Cell Disease
- ☐ Vision Impairment
- ☐ Hearing Impairment
- ☐ Chronic Skin Disease
- ☐ Recurrent Boils
- ☐ Recurrent Skin Infections
- ☐ Anemia
- ☐ Severe Headaches
- ☐ Broken or Cracked Bones
- ☐ Severe Sprains or Dislocations
- ☐ Severe Lacerations
- ☐ Concussion or Head Injury
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Blood Clots
- ☐ Elevated Cholesterol
- ☐ DES Exposure: (Did your mother take while she carried you to prevent miscarriage?)
- ☐ AIDS / AIDS Related Disease

IMMUNIZATION HISTORY:

HAVE YOU HAD:

	YES	NO	DATE OF LAST
Hemophilus Influenzae Vaccine (HIB)	☐	☐	
Pneumonia / Influenzae Shot	☐	☐	
Measles & Mumps Shots	☐	☐	
Polio Vaccine	☐	☐	
Tetanus Shot	☐	☐	
Diphtheria Shot	☐	☐	
TB Skin Test (pos / neg)	☐	☐	
Hepatitis Shots	☐	☐	
Rubella Shot or Blood Test	☐	☐	

LIST ALL ALLERGIES:

MEDICATIONS:

LIST ALL MEDICATIONS TO INCLUDE VITAMINS, OVER THE COUNTER MEDICATIONS AND HERBAL PREPARATIONS

Patient Name:_____

DOB:_____

Or label

Name / MR # / Label

To be completed by the patient.

SEXUAL AND REPRODUCTIVE HEALTH

QUESTION FOR WOMEN ONLY:

MENSTRUATION:
Age Periods Began: _____
Cycle Length: _____
Period Length: _____
Last Menstrual Period: _____

FLOW
☐ Heavy ☐ Medium ☐ Light

DISCOMFORT
☐ Severe ☐ Moderate ☐ Mild

PMS (Pre-Menstrual Syndrome)
☐ Yes ☐ No

PREGNANCIES:
Total Number: _____
Full Term: _____
Premature: _____
Stillbirth: _____
Miscarriages: _____
Abortions: _____
Tubal Pregnancy: _____

PREGNANCY COMPLICATIONS
_____

QUESTION FOR BOTH MEN AND WOMEN:

Do you use a form of birth control? ☐ No ☐ Yes If yes, what kind(s)?
_____
Have you ever had any sexually transmitted diseases? ☐ No ☐ Yes
If Yes, what kind(s) _____
How would you describe your sexual orientation?
_____
Do you have any questions or problems in regard to your sex life?
_____
Do you have any concerns about your fertility? ☐ No ☐ Yes
_____
What type of concerns: _____

PERSONAL HISTORY

MARITAL HISTORY
My current status is: ☐ Married ☐ Single ☐ Widowed ☐ Divorced
With whom do you now live? _____

EDUCATION & OCCUPATION:
Highest education achieved? _____
Present position / employment? _____
Previous job? _____
Exposure to toxins at work? ☐ No ☐ Yes – Type? _____
Do you have current vocational concerns? ☐ No ☐ Yes If so, please list
_____
_____

RELIGION
Religious preference: _____
Church Affiliation: _____
Do you have any specific cultural needs? ☐ No ☐ Yes
If Yes, explain: _____

SPECIAL NEEDS:
Do you have a developmental disability? ☐ No ☐ Yes
If Yes, describe: _____
_____
Will you require special assistance during your visit? ☐ No ☐ Yes
What type? _____
_____

DIET, EXERCISE & HABITS:
Do you follow a special diet? _____
Weight? Current: _____ Desired: _____ 1 year ago: _____
Exercise? What kind of exercise do you do? _____
_____

PAIN
Do you have physical pain? ☐ No ☐ Yes
If yes, on a scale from 1 – 10 (10 worst) how is it now? _____
Cause of pain if present: _____

TOBACCO USE:
How much do you smoke? ☐ None ☐ Regularly _____ / per day
Have you quit smoking? ☐ No ☐ Yes – When? _____
Do you use any other tobacco? ☐ No ☐ Yes – What? _____

ALCOHOL USE:
Do you drink alcohol? ☐ No ☐ Yes
Have you had any problems with your drinking? ☐ No ☐ Yes
If Yes, please explain: _____
_____
What is your drinking pattern? _____
_____
Do you use recreational drugs? ☐ No ☐ Yes
What type? _____
_____

LEGAL:
Do you have any current legal issues pending? ☐ No ☐ Yes
If Yes, describe: _____
_____
Past convictions? ☐ No ☐ Yes If Yes, describe: _____
_____

VIOLENCE / ABUSE
Is violence at home or work a concern for you? ☐ No ☐ Yes
If Yes, describe: _____
_____
Have you ever been abused? ☐ No ☐ Yes
By whom: _____

_____
Patient's Signature Date/Time

_____
Healthcare Provider Signature / Stamp Date/Time

If limited English proficient or hearing impaired, offer interpreter at no additional cost:
☐ Interpreter Accepted _____ ☐ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)

Patient Name:_____

DOB:_____

Or label

Name / MR # / Label