PERSONAL HEALTH HISTORY QUESTIONNAIRE DATE: _____

Patient Name:	**Date Of Birth**	**Age:**
Occupation:	**Employer:**	
With Whom Do You Live?	**On Whom Do You Depend On For Transportation?**	
Partner Status: ☐Married ☐Single ☐Divorced ☐ Separated ☐Widowed ☐ Domestic Partner		
Religion:	**Level of Education Completed:**	**Number of Children:**

FAMILY HISTORY

If any blood relative has suffered from any of the following, please check and indicate which relative in the space provided: *Please List **ALL** Blood Relatives - GP= Grandparent, S= Sibling, M= Mother, F= Father*

☐ Alcoholism_____	☐ Clotting Disorders _____	☐ High Cholesterol_____	☐ Stroke _____
☐ Allergy_____	☐ Diabetes _____	☐ Hypertension _____	☐ Stomach Problems _____
☐ Anemia_____	☐ Dementia _____	☐ Mental Illness_____	☐ Tuberculosis _____
☐ Arthritis _____	☐ Glaucoma _____	☐ Migraine_____	☐ Breast Cancer _____
☐ Asthma_____	☐ Heart Disease_____	☐ Osteoporosis_____	☐ Colon Cancer _____
		☐ Seizures_____	☐ Other Cancer _____

If Mother Deceased, Age & Cause of Death:

_____

If Father Deceased, Age & Cause of Death:

_____

HOSPITAL ADMISSIONS (Please Include **Pregnancies** & **Past Illnesses**)	**YEAR**	**ILLNESS/OPERATION**		**YEAR**	**ILLNESS/OPERATION**

List <u>Name & Dosage of All Medications</u> That You Are Taking Please Include: Prescriptions, Supplements, & Non-

1.	4.	7.
2.	5.	8.
3.	6.	9.

ALLERGIES If none, please check box: Please List All Known Allergies, Especially to Medicines or Anesthesia.

Please List The Month & Year Of Your Most Recent: Tests, Exams and Immunizations

Advance Directive:	Power of Attorney:	POLST Form:
Eye Exam:	Stool Card:	Pneumonia Vaccine (65 yrs. and older):
Diabetic Foot Exam:	Colonoscopy:	Shingles Vaccine (60 yrs. and older):
Mammogram:	Cholesterol Screen:	Hepatitis Vaccine:
PAP Smear:	Tetanus Shot (every 10 years):	HPV:
Bone Density:	Flu Shot:	TB Skin Test:

List Health Care Providers That You See Currently (Or Have Seen) For Your Major Medical Problems

WHAT QUESTIONS MAY I ANSWER FOR YOU CONCERNING YOUR HEALTH?

PLEASE CHECK THE ITEMS BELOW THAT YOU HAVE NOW OR HAVE HAD IN THE PAST

HEENT	Present	Past
Wear Glasses/Contacts	☐	☐
Glaucoma	☐	☐
Difficulty Hearing/Seeing	☐	☐
Dry Eyes	☐	☐
Blood Shot Eyes	☐	☐
Ringing In the Ears	☐	☐
Ear Wax Problems	☐	☐
Ear Pain	☐	☐
Dizziness	☐	☐
Chronic Sinus Infection	☐	☐
Frequent Nose Bleed	☐	☐
Hay Fever	☐	☐
Dental Problems	☐	☐
Bleeding Gums/Sores Mouth	☐	☐
Voice Change	☐	☐
Radiation Therapy Neck/Head	☐	☐

CV-RESP	Present	Past
High Blood Pressure	☐	☐
Leg Pain with Walking/Resting	☐	☐
High Cholesterol/Triglyceride	☐	☐
Anemia (Low Blood Count)	☐	☐
Bleeding or Bruising Easily	☐	☐
Heart Disease or Murmur	☐	☐
Chest Pain	☐	☐
Racing, Pounding Heart	☐	☐
Varicose Veins/Blood Clots	☐	☐
Ankle Swelling	☐	☐
Fingers Change Color & Hurt	☐	☐
Shortness of Breath	☐	☐
Difficulty Laying Flat	☐	☐
Lung or Breathing Problems	☐	☐
Asthma/ Wheezing	☐	☐
Emphysema	☐	☐
Chronic Cough	☐	☐
Coughing Up Blood	☐	☐
Abnormal Chest X-Ray	☐	☐
Pneumonia	☐	☐

GI	Present	Past
Chronic Abdominal Pain	☐	☐
Ulcers	☐	☐
Frequent Nausea or Vomiting	☐	☐
Vomiting Blood	☐	☐
Bloody or Black Stools	☐	☐
Heartburn	☐	☐
Gallbladder Disease	☐	☐
Change in Appetite	☐	☐
Swallowing Problem	☐	☐
Hernia	☐	☐
Hemorrhoids	☐	☐
Polyps	☐	☐
Diarrhea/ Constipation	☐	☐
Rectal Bleeding	☐	☐
Change in Stool Size/Shape	☐	☐

GU	Present	Past
Frequent Urination	☐	☐
Leaking Urine/ Dribbling	☐	☐
Urination at Night > 1 Time	☐	☐
Pain or Blood on Urination	☐	☐
Kidney or Bladder Infection	☐	☐
Kidney Stone	☐	☐
Difficulty Urinating	☐	☐

MALES ONLY	Yes	No
Change in Stream	☐	☐
Prostate Trouble	☐	☐
Lumps on Testicles	☐	☐
Difficulty with Erections	☐	☐

NEURO-MUSCULAR	Present	Past
Headaches	☐	☐
Seizures	☐	☐
Passing Out/Fainting	☐	☐
Speech Problem	☐	☐
Weakness or Paralysis	☐	☐
Coordination Problem	☐	☐
Tremors or Unsteadiness	☐	☐
Memory/Thinking Problem	☐	☐
Arthritis or Gout	☐	☐
Red/Swollen/Stiff Joints	☐	☐
Bursitis	☐	☐
Back or Neck Pain	☐	☐
Painful Joints/Muscle/Bones	☐	☐
Osteoporosis	☐	☐

SKIN	Present	Past
Skin Disorders	☐	☐
Rashes/Itching	☐	☐
Hives	☐	☐
Eczema	☐	☐
Acne	☐	☐
Moles Changing Size/Color	☐	☐
Dry or Oily Skin	☐	☐

METABOLIC	Present	Past
Weight Gain or Loss	☐	☐
Unusual Fatigue	☐	☐
Sleep Problems	☐	☐
Thyroid Problems	☐	☐
Diabetes (High Blood Sugar)	☐	☐
Low Blood Sugar	☐	☐
Heat or Cold Intolerance	☐	☐
Nervous or Anxious	☐	☐
Unusual Loss of Hair	☐	☐
Unusual Diet	☐	☐

FEMALES ONLY	Yes	No
Age of First Menses _____		
First Day of Last Menses _____		
Menstrual Trouble	☐	☐
Vaginal Discharge	☐	☐
Abnormal Bleeding	☐	☐
Difficulty Getting Pregnant	☐	☐
Breast Lump or Pain	☐	☐
Do You Do Self-Breast Exams	☐	☐
#Pregnancies _____		
#Miscarriages_____		
#Abortions _____		
#C-Sections _____		
Pregnancy Complications	☐	☐
Currently Pregnant	☐	☐
Emotional Changes	☐	☐

MENOPAUSE	Yes	No
Hormone Replacement	☐	☐
Hot Flashes/ Night Sweats	☐	☐

BOTH MALES AND FEMALES	Yes	No
Sexually Transmitted Diseases	☐	☐
Sexual Concerns	☐	☐

Partner Preference

☐ Male ☐ Female ☐ Both

Type of Birth Control Used
(If Needed/Desired)

_____

ILLNESSES	Present	Past
Polio	☐	☐
Hepatitis	☐	☐
Tuberculosis	☐	☐
Rheumatic Fever	☐	☐
Drug/Alcohol Addiction	☐	☐
Mental Illness	☐	☐

EMOTIONAL	Yes	No
Partner Relations Good	☐	☐
Lack of Sex Drive	☐	☐
Enjoy Employment	☐	☐
Unhappy or Depressed	☐	☐
Crying Spells	☐	☐
Suicidal Thought/Intent	☐	☐
Depression	☐	☐
Victim of Domestic Violence	☐	☐

Thank You for Your Time!

Name:

_____

Spiritual History Section

Please answer the following questions:

1. **S= Sources of Strength** (What gives you inner Strength and Support?

_____

_____

_____

2. **O=Outlook on religion and beliefs** (What religion, faith group, or belief shapes you most?)

_____

_____

_____

3. **U=Underlying life events** (What significant issues or life events (gains or losses) do you want us to be aware of as we care for you?)

_____

_____

_____

4. **L=Links to care** (What religious practices or beliefs would you like us to consider as we care for you?)

_____

_____

_____