CommunityHealth

HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. Add any notes you think are important. **ALL INFORMATION CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.**

Name: _____ Date of Birth: _____

Main reason for your visit: _____

SOCIAL HISTORY - Please answer all questions

Occupation:	Chewing Tobacco: ☐No ☐Yes
Highest Education Level Achieved:	Drug Use: ☐No ☐Yes Type:
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐ Domestic Partner	Number of sexual partners in the past year:
Sexual Orientation: ☐Heterosexual ☐Homosexual ☐Bisexual	Smoking Status: ☐Never ☐Former ☐Current
Alcohol (Number drinks per week):	Number cigarettes per day: Number of years:
Do you have an advanced directive (plan for end of life health care)? ☐Yes ☐No ☐Don't know Would you like info about how to make one? ☐Yes	Does anyone in your home smoke? ☐Yes ☐No

Please answer all questions. Check "☐ None" if the question does not apply.

CURRENT MEDICATIONS – Please list ALL medications you currently take, including over-the-counter, natural, and herbal medications. **☐ None**

1.
2.
3.
4.
5.
6.

MEDICATION ALLERGIES - List all medication allergies and your reaction **☐ None**

1.
2.

PAST MEDICAL HISTORY - Please check the box if you have had these symptoms or problems. ☐ **None**

☐ Allergies, Seasonal	☐ Ear or Hearing Problems	☐ Osteoporosis
☐ Anemia	☐ Fibromyalgia	☐ Rheumatoid arthritis
☐ Anxiety Disorder	☐ Gout	☐ Seizures/Epilepsy
☐ Arthritis	☐ Headaches/Migraines	☐ Sexual Problems
☐ Asthma	☐ Heart Attack	☐ Shortness of breath
☐ Bipolar disorder	☐ Heart Disease	☐ Sickle cell disease
☐ Birth Defects or Inherited Disease	☐ Heart Murmur	☐ Skin Problems
☐ Bleeding disorder	☐ Hepatitis	☐ Stroke
☐ Blood clots	☐ High Blood Pressure	☐ Thoughts of hurting yourself/others
☐ Blood Transfusions	☐ High Cholesterol	☐ Thyroid Problems
☐ Cancer	☐ Kidney Disease	☐ Traumatic accident or Injuries
☐ Chest Pain	☐ Liver Disease	☐ Tuberculosis
☐ Constipation	☐ Loss of Memory/Consciousness	☐ Ulcer/Other GI Problems
☐ Depression	☐ Lung Disease/Pneumonia	☐ Urinary problems
☐ Diabetes	☐ Multiple Sclerosis	☐ Vision or Eye Problems
If you checked a box in Past Medical History above, please explain:		

HEALTH SCREENINGS - Please check the box if you have recently completed these tests and list the date of the test and if the result was normal or abnormal ☐ **None**

Screening/Test Type	Month/Year	Result Normal or Abnormal
☐ Colon cancer test (list what type)		
☐ Mammogram		
☐ Pap smear		

YOUR PROVIDERS – List the doctors, clinics, and hospitals you have visited in the last 3 years. If possible, please list and their address, phone, and fax, if available

Name of clinic, hospital, or doctor	Address	Phone number	Fax number

OTHER HOSPITALIZATIONS (if any) ☐ **None**

Month/Year	Reason/Illness

SURGICAL PROCEDURES/OPERATIONS (if any) ☐ **None**

Month/Year	Operation

GYN & PREGNANCY HISTORY

Currently Pregnant: ☐Yes ☐No	Number of pregnancies: Number of living children:
Age at First Menstrual Period:	Date of Last Menstrual Period:
Current Birth Control Method:	If postmenopausal, age at menopause:

FAMILY HISTORY – Please indicate any conditions experienced by people in your family below ☐ **None**

	Mother	Father	Brother	Sister	Maternal grandmother	Maternal grandfather	Paternal grandmother	Paternal grandfather
Alcohol/ Substance Abuse								
Asthma								
Bleeding Disorders								
Cancer								
Dementia/ Alzheimer's								
Diabetes								
Epilepsy/Seizures								
Headaches/ Migraines								
Heart Problem								
High Cholesterol								
High Blood Pressure								
Immune Problems								
Kidney Disease								
Liver Problems								
Neurologic Problems								
Osteoporosis								
Psychiatric Problems								
Rheumatoid Arthritis								
Stroke								
Thyroid Problems								

The information above about my health history is accurate. I will inform CommunityHealth as changes or updates occur.

_____ _____

Patient Signature Date