NEW Health

Patient Name: _____ Date of Birth: _____

Date: **HEALTH HISTORY QUESTIONNAIRE**

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit:

_____

Other concerns:

_____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.	Reaction (ie: Hives)
1.	
2.	
3.	
4.	

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	Strength/Dose	Frequency Taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

IMMUNIZATIONS

Immunizations most recent date:			
Chickenpox	Date:	Meningococcus	Date:
Flu Shot	Date:	MMR (Measles, Mumps, Rubella)	Date:
Gardasil/HPV	Date:	Pneumonia	Date:
Hepatitis A	Date:	Tdap (Tetanus and pertussis)	Date:
Hepatitis B	Date:	Tetanus	Date:
PCV	Date:	Zostavax (Shingles)	Date:

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(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear: ☐Normal ☐Abnormal	☐Bleeding between periods
Last Mammogram: ☐Normal ☐Abnormal	☐Heavy periods
Age of first menstrual period:	☐Extreme menstrual pain
First day of your last normal menstrual period: ☐Menopausal	☐ Vaginal itching, burning, discharge
Pregnancy/ Delivery History: # Pregnancies ___ # Term (>37 weeks) ___ # Preterm (< 37 weeks) ____ # Abortions /Miscarriages_____ # Living Children_____ # Cesarean Sections ____	☐Wake in the night to urinate ☐Hot flashes ☐Breast lump or nipple discharge

CONTRACEPTION AND SEXUAL HISTORY (if applicable)

Sexually Active: ☐Yes ☐ No	Current sexual partner is: ☐Female ☐Male	Painful Intercourse: ☐Yes ☐ No
Current Contraception Method: Do you use condoms? ☐Yes ☐No (List Contraception Methods)		Interested in being screened for STI's? ☐YES ☐ NO

PAST MEDICAL HISTORY

Please check all that apply:		
☐ Anxiety/Depression	☐ Diverticulitis	☐Kidney Disease
☐ Arthritis	☐ Fibromyalgia	☐ Kidney Stones
☐ Asthma	☐Gout	☐Leg/Foot Ulcers
☐ Bleeding Disorder	☐Has Pacemaker	☐ Liver Disease
☐ Blood Clots (or DVT)	☐ Heart Attack	☐ Osteoporosis
☐ Cancer	☐ Heart Murmur	☐ Polio
☐Coronary Artery Disease	☐Hiatal Hernia or Reflux	☐ Pulmonary Embolism
☐ Claustrophobic	☐HIV or AIDS	☐ Reflux or Ulcers
☐ Diabetes - Insulin	☐High Cholesterol	☐ Stroke
☐ Diabetes - Non-Insulin	☐High Blood Pressure	☐Tuberculosis
☐Dialysis	☐Overactive Thyroid	☐ Other

PAST SURGICAL HISTORY

SURGERY (list additional on separate page if needed)	YEAR	HOSPITAL

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FAMILY HEALTH HISTORY

RELATION	LIVING	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N		☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐ Diabetes ☐Genetic disease ☐Heart disease ☐ Hypertension ☐Stroke ☐Osteoporosis
Grandfather (maternal)	Y/N		☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐ Diabetes ☐Genetic disease ☐Heart disease ☐ Hypertension ☐Stroke ☐Osteoporosis
Grandmother (paternal)	Y/N		☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐ Diabetes ☐Genetic disease ☐Heart disease ☐ Hypertension ☐Stroke ☐Osteoporosis
Grandfather (paternal)	Y/N		☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐ Diabetes ☐Genetic disease ☐Heart disease ☐ Hypertension ☐Stroke ☐Osteoporosis
Father	Y/N		☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐ Diabetes ☐Genetic disease ☐Heart disease ☐ Hypertension ☐Stroke ☐Osteoporosis
Mother	Y/N		☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐ Diabetes ☐Genetic disease ☐Heart disease ☐ Hypertension ☐Stroke ☐Osteoporosis
Brother/Sister	Y/N		☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐ Diabetes ☐Genetic disease ☐Heart disease ☐ Hypertension ☐Stroke ☐Osteoporosis
Brother/Sister	Y/N		☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐ Diabetes ☐Genetic disease ☐Heart disease ☐ Hypertension ☐Stroke ☐Osteoporosis
Other: _____	Y/N		☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐ Diabetes ☐Genetic disease ☐Heart disease ☐ Hypertension ☐Stroke ☐Osteoporosis

SOCIAL HISTORY

Education	Marital Status	Exercise Level
☐ Less than 8th grade	☐ Married	☐ None
☐ High School	☐ Divorced	☐ Occasional
☐ 2 Year College	☐ Single	☐ Moderate
☐ 4 Year College	☐ Separated	☐ Heavy
☐ Post Graduate	☐ Widowed	
	☐ Domestic Partner	

NEW Health

Patient Name: _____ Date of Birth: _____

Tobacco Use	Drug Use	Caffeine Use
Do you currently smoke? ☐Y☐N	Do you currently use recreational or street drugs? ☐Y ☐N	☐ None
Did you ever use tobacco? ☐Y ☐N Quit date:	If yes, list:	☐ Occasional
How many years have you smoked? ____ Years		☐ Moderate
Cigarettes Per Day? ____ Cigarettes daily	Have you ever used recreation or street drugs? ☐Y ☐N	☐ Heavy
Do you use chewing tobacco?☐ Y☐N	If yes, list:	# of cups/cans per day?_____
If yes, how many times a day? ____ Times a day		
How many years have you chewed? ____ Years		Type of Caffeine?
Do you or have you used a Vaping Device?☐ Y ☐N		☐Coffee
If yes, how often per day? _____Times a day		☐Tea ☐Soda ☐Energy Drinks
Alcohol Use	**Nutrition- Diet**	
☐ None ☐ Occasionally ☐ Moderate ☐ Heavy ☐ How many drinks per week?	☐ Normal Diet ☐ Low Salt Diet ☐ Low Carb Diet ☐ Low Calorie Diet ☐ Other:	

Please enter any other additional information below about your health that you would like your provider to know.

Patient Signature (Parent, Guardian or Caregiver Signature)

Signed: Date: