

HEALTH HISTORY QUESTIONNAIRE

Patient Name _____ E-mail _____
Date of Birth _____ Phone _____

Please list recent physicians involved in your health care and their location:

<u>Provider</u>	<u>Location</u>
_____	_____
_____	_____
_____	_____
_____	_____

Do you have a history of the following conditions?

	<u>Yes</u>	<u>No</u>	<u>Details</u>
Diabetes	_____	_____	_____
Heart Disease	_____	_____	_____
High Blood Pressure	_____	_____	_____
High Cholesterol	_____	_____	_____
Cancer	_____	_____	_____
Chronic Pain	_____	_____	_____
Lung Disease	_____	_____	_____
Other	_____	_____	_____

Please list past surgeries and the year performed:

<u>Surgery</u>	<u>Year Performed</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any preventive health care procedures:

<u>Procedure</u>	<u>Yes</u>	<u>No</u>	<u>When? (Most recent)</u>
Colonoscopy	_____	_____	_____
PAP	_____	_____	_____
Mammogram	_____	_____	_____
Bone Density Scan	_____	_____	_____

Please list medications you are currently taking including supplements and herbs:

<u>Name</u>	<u>Dose</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Preferred Pharmacy _____

Please list any allergies:

Please tell us about yourself:

Marital Status (please circle) Single/Divorced Married Widowed
Children (age) _____
Occupation (past, present or disabled) _____
Smoking (packs per day and number of years) _____
Alcohol (number of drinks per day) _____
Illicit Drug Use (present and past) _____

Family History:

<u>Health Problem</u>	<u>Relation to you, age of family member and cause of death (if deceased)</u>
Cancer	_____
Heart Disease	_____
Stroke	_____
Diabetes	_____
High Blood Pressure	_____
Mental Illness	_____
Other	_____

Review of Systems (Circle all that apply)

CONSTITUTIONAL

Fatigue
Fevers
Night sweats

CARDIAC

Chest pain or pressure
Racing or irregular heartbeat
Leg pain when walking

METABOLIC

Intolerance to heat
Intolerance to cold
Excessive thirst
Excessive hunger

SKIN

Rashes
Itching
Breast lumps

EYES

Discharge
Vision loss

GASTROINTESTINAL

Abdominal pain
Constipation
Diarrhea
Vomiting

NEUROLOGIC

Memory loss
Abnormal gait
Dizziness
Headaches
Seizures

MUSCULOSKELETAL

Joint pain
Muscle weakness
Cramping

EAR, NOSE & THROAT

Hearing loss
Ear drainage
Nasal drainage

HEMATOLOGIC/LYMPHATIC

Easy bruising
Easy bleeding

GENITOURINARY

Pain with urination
Blood in urine
Penile or vaginal discharge
Excessive urination

RESPIRATORY

Shortness of breath
Wheezing

PSYCHIATRIC

Depression
Anxiety

IMMUNOLOGIC

Seasonal allergies
Food allergies

This form will be reviewed by the physician you have selected prior to acceptance as a new patient and prior to an appointment being scheduled.

I release the enclosed information to Boundary Community Clinics. In the event I am not accepted as a patient, I understand this information will be destroyed. If I am accepted as a patient, this information will be stored in my chart.

Patient Signature _____

Date _____