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HEALTH HISTORY QUESTIONNAIRE

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

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

Provider	Location
_____	_____
_____	_____
_____	_____
_____	_____

Do you have a history of the following conditions?

	Yes	No	Details
Diabetes	___	___	_____
Heart Disease	___	___	_____
High Blood Pressure	___	___	_____
High Cholesterol	___	___	_____
Cancer	___	___	_____
Chronic Pain	___	___	_____
Lung Disease	___	___	_____
Other	_____		_____

Please list past surgeries and the year performed:

Surgery	Year Performed
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any preventive health care procedures:

Procedure	Yes	No	When? (Most recent)
Colonoscopy	___	___	_____
PAP	___	___	_____
Mammogram	___	___	_____
Bone Density Scan	___	___	_____

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

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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:

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

Review of Systems (Circle all that apply)

CONSTITUTIONAL	CARDIAC	METABOLIC	SKIN
Fatigue	Chest pain or pressure	Intolerance to heat	Rashes
Fevers	Racing or irregular heartbeat	Intolerance to cold	Itching
Night sweats	Leg pain when walking	Excessive thirst	Breast lumps
		Excessive hunger	

EYES	GASTROINTESTINAL	NEUROLOGIC	MUSCULOSKELETAL
Discharge	Abdominal pain	Memory loss	Joint pain
Vision loss	Constipation	Abnormal gait	Muscle weakness
	Diarrhea	Dizziness	Cramping
	Vomiting	Headaches	
		Seizures	

EAR, NOSE & THROAT	HEMATOLOGIC/LYMPHATIC	GENITOURINARY	RESPIRATORY
Hearing loss	Easy bruising	Pain with urination	Shortness of breath
Ear drainage	Easy bleeding	Blood in urine	Wheezing
Nasal drainage		Penile or vaginal discharge	
		Excessive urination	

PSYCHIATRIC	IMMUNOLOGIC
Depression	Seasonal allergies
Anxiety	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 _____