

# HEALTH HISTORY QUESTIONNAIRE



LANDER HOPE CLINIC

Please complete this entire questionnaire. It will provide your care team with important information about your health. All answers contained in this questionnaire are strictly confidential and will become part of your medical record.

**Name** (Last, First, M.I.): \_\_\_\_\_  M  F **DOB:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Marital status:**  Single  Partnered  Married  Separated  Divorced  Widowed

**Address:** \_\_\_\_\_ **Phone number** \_\_\_\_\_

**Email address:** \_\_\_\_\_

## PERSONAL HEALTH HISTORY

**Childhood Illness:**  Measles  Mumps  Rubella  Chickenpox  Rheumatic Fever  Polio  None

**Immunizations and Dates:**  Tetanus \_\_\_\_\_  Pneumonia \_\_\_\_\_  Hepatitis A \_\_\_\_\_  Hepatitis B \_\_\_\_\_

Chickenpox \_\_\_\_\_  Influenza \_\_\_\_\_  MMR *Measles, Mumps, Rubella* \_\_\_\_\_  Meningococcal \_\_\_\_\_  None

**Tests/Screenings and Dates:**  Eye Exam \_\_\_\_\_  Colonoscopy \_\_\_\_\_  Dexa Scan \_\_\_\_\_

### Surgeries

Year \_\_\_\_\_ Reason \_\_\_\_\_ Hospital \_\_\_\_\_

Year \_\_\_\_\_ Reason \_\_\_\_\_ Hospital \_\_\_\_\_

Year \_\_\_\_\_ Reason \_\_\_\_\_ Hospital \_\_\_\_\_

Year \_\_\_\_\_ Reason \_\_\_\_\_ Hospital \_\_\_\_\_

I have had no surgeries

### Other hospitalizations

Year \_\_\_\_\_ Reason \_\_\_\_\_ Hospital \_\_\_\_\_

Year \_\_\_\_\_ Reason \_\_\_\_\_ Hospital \_\_\_\_\_

Year \_\_\_\_\_ Reason \_\_\_\_\_ Hospital \_\_\_\_\_

Year \_\_\_\_\_ Reason \_\_\_\_\_ Hospital \_\_\_\_\_

I have never been hospitalized

Have you ever had a blood transfusion?  Y  N

Please list other physicians you have seen in the last 12 months, and for what reason.

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# Patient Health Questionnaire

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

*Please check the box next to conditions or diseases that apply to your health. If you are uncertain, place a question mark (?) next to the statement. If there is more than one choice on a line, circle the conditions that apply.*

	YES	NO
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	YES	NO
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### General

Have you taken Medicine in the last 6 months?		
Have you seen a doctor in the last 3 years?		
History of Heart, Lung, or Liver transplant		

### Neurologic

Stroke or transient ischemic attack (TIA)		
Seizures or epilepsy		
Brain tumor or cerebral aneurysm		
Multiple sclerosis (MS)		
Parkinson's disease		
Cerebral Palsy		
Myasthenia Gravis		
Deep brain stimulator		
Spinal cord stimulator		
Intrathecal pain pump		
Other:		

### Pulmonary

COPD or emphysema		
Use oxygen at home		
Use oxygen out of home		
Asthma		
Chronic bronchitis or cough		
Recent pneumonia or lung infection		
OSA or obstructive sleep apnea		
Use CPAP or BiPAP at home		
Lung surgery or pneumonectomy		
Snore loudly enough to be heard outside room		
Feel tired, sleepy, or fatigued during the day		
Been observed not breathing during sleep		
Interstitial lung disease or pulmonary fibrosis		
Pulmonary hypertension		
COVID		

### Head, Eye, Ear, Nose & Throat

Vision loss		
Dysphagia or trouble swallowing		
Hearing loss		
History of radiation to the head or neck		
Other:		

### Gastrointestinal

GERD, gastric reflux, or heartburn		
Hiatal hernia		
Peptic ulcer disease or stomach ulcers		
Recent upper or lower GI bleeding (< 6		
Pancreatitis		
Hepatitis or Jaundice		
Cirrhosis of the liver or liver failure		
Colitis or Crohn's disease		
Liver transplant		
Gallstones		
Other:		

### Cardiovascular

Heart attack or myocardial infarction		
Heart disease (CAD), chest pain, angina		
Heart stents or angioplasty		
Use nitroglycerin		
High blood pressure or hypertension		
High cholesterol or hyperlipidemia		
Abnormal EKG or an arrhythmia		
Pacemaker, defibrillator, or ICD		
Atrial fibrillation or a-fib		
Left bundle branch block		
Bypass or other heart surgery		
Mitral or aortic heart valve problem		
Heart murmur or mitral valve problem		
Congestive heart failure or cardiomyopathy		
Peripheral vascular disease (blocked artery)		
Aortic aneurysm or dissection		
Carotid artery disease		
Other:		

### Genitourinary

Renal/ kidney failure dialysis/ CKD		
Enlarged prostate or BPH		
Kidney transplant		
Polycystic kidney disease		
Urinary retention		
Kidney stones		

### Gynecologic

Fibroid uterus		
Ovarian cysts or polycystic ovarian disease		
Dysfunctional uterine bleeding		
Other:		



# Patient Health Questionnaire

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

	YES	NO
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### Endocrine

Insulin dependent diabetes		
Non-Insulin dependent diabetes		
Diabetes Controlled with diet		
Hypothyroidism or low thyroid		
Hypothyroidism or overactive thyroid		
Insulin Pump		
Other:		

### Musculoskeletal

Rheumatoid Arthritis		
Osteoarthritis		
TMJ (jaw joint problems)		
Degenerative joint disease		
Cervical spine problem (neck)		
Thoracic spine problem (middle back)		
Lumbar spine problem (lower back)		
Spinal stenosis		
Scoliosis		
Polymyalgia rheumatica		
SLE (systemic lupus erythematosus)		
Connective tissue disease or scleroderma		
Chronic back pain		
Fibromyalgia		
Other:		

### Hematology– Oncology

Anemia		
Abnormal bleeding or bruising		
On Coumadin		
Other blood thinning medication (not aspirin)		
DVT or deep vein thrombosis (blood clot)		
IVC filter		
Pulmonary embolism (blood clot in the lung)		
Sickle cell disease		
Von Willebrand's disease		
Refuse blood or blood products		
Previous blood transfusion		
<b>Check the box &amp; circle which applies</b>		
Head or neck cancer		
Breast, prostate, or skin cancer		
Pancreatic, stomach, or esophageal cancer		
Cervical, ovarian, or endometrial cancer		
Colon, rectal, or anal cancer		
Kidney or bladder cancer		
Lung or liver cancer		
Lymphoma or leukemia		
Chemotherapy or radiation		
Other:		

### Are you in PAIN? [Please rate]

(No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst)

	YES	NO
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### Immunology– Infectious Disease

Immune system disorder		
Hepatitis B or C		
HIV or AIDS		
History of tuberculosis		
On immunosuppressive therapy		
Other:		

### Psychiatric

Depression or bipolar disorder		
Anxiety disorder		
Schizophrenia		
Dementia		
Other:		

### Nutrition

Do you eat meat?		
Do you eat dairy products?		
Do you eat eggs?		
Are you vegan?		
Are you vegetarian?		
Do you have food allergies?		

### Anesthesia History

Malignant hyperthermia or family history of MH		
Difficult airway mgt. (placing breathing tube)		
Post operative nausea		
Severe post operative nausea and vomiting		
Intraoperative awareness		
Severe allergy to anesthesia		
Anaphylactic reaction during surgery		
Nerve injury related to surgery or anesthesia		
Unanticipated stay in ICU after surgery		
Have you been in an ICU for a week or longer		
Get short of breath when you lay on your back		
Other:		

### History

Do you get short of breath with heavy house or yard work OR with climbing 1 flight of stairs?		
Do you exercise regularly?		
Marital Status _____		
Number of Children _____		
How many live with you _____		
Date of last physical exam _____		

Do you take narcotics for pain on a daily basis?  
Yes No

Name (Last, First, M.I.): \_\_\_\_\_ DOB \_\_\_\_\_

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Alcohol Abuse           | <input type="checkbox"/> Growth/Development Disorder | <input type="checkbox"/> Migraines   |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Hearing Impairment          | <input type="checkbox"/> Osteoporosis  |
| <input type="checkbox"/> Anesthetic Complication | <input type="checkbox"/> Heart Attack                | <input type="checkbox"/> Prostate Cancer                                       |
| <input type="checkbox"/> Anxiety Disorder        | <input type="checkbox"/> Heart Disease               | <input type="checkbox"/> Rectal Cancer   |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Heart Pain/Angina           | <input type="checkbox"/> Reflux/GERD   |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Hepatitis A                 | <input type="checkbox"/> Seizures/Convulsions                                  |
| <input type="checkbox"/> Autoimmune Problems     | <input type="checkbox"/> Hepatitis B                 | <input type="checkbox"/> Severe Allergy  |
| <input type="checkbox"/> Birth Defects           | <input type="checkbox"/> Hepatitis C                 | <input type="checkbox"/> Sexually Transmitted Disease                          |
| <input type="checkbox"/> Bladder Problems        | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Skin Cancer   |
| <input type="checkbox"/> Bleeding Disease        | <input type="checkbox"/> High Cholesterol            | <input type="checkbox"/> Stroke/CVA of the Brain                               |
| <input type="checkbox"/> Blood Clots             | <input type="checkbox"/> HIV                         | <input type="checkbox"/> Suicide Attempt                                       |
| <input type="checkbox"/> Blood Transfusion(s)    | <input type="checkbox"/> Hives                       | <input type="checkbox"/> Thyroid Problems                                      |
| <input type="checkbox"/> Bowel Disease           | <input type="checkbox"/> Kidney Disease              | <input type="checkbox"/> Ulcer   |
| <input type="checkbox"/> Breast Cancer           | <input type="checkbox"/> Liver Cancer                | <input type="checkbox"/> Visual Impairment                                     |
| <input type="checkbox"/> Cervical Cancer         | <input type="checkbox"/> Liver Disease               | <input type="checkbox"/> Other Disease, Cancer, or Significant Medical Illness |
| <input type="checkbox"/> Colon Cancer            | <input type="checkbox"/> Lung Cancer                 | <input type="checkbox"/> NONE of the Above                                     |
| <input type="checkbox"/> Depression              | <input type="checkbox"/> Lung/Respiratory Disease    |  |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Mental Illness              |  |

List any other past family medical problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List your prescribed drugs and over-the-counter drugs, vitamins, minerals, lotions and potions, herbs, supplements and inhalers

Drug _____	Dose/ Frequency _____	Drug _____	Dose/ Frequency _____
Drug _____	Dose/ Frequency _____	Drug _____	Dose/ Frequency _____
Drug _____	Dose/ Frequency _____	Drug _____	Dose/ Frequency _____
Drug _____	Dose/ Frequency _____	Drug _____	Dose/ Frequency _____
Drug _____	Dose/ Frequency _____	Drug _____	Dose/ Frequency _____
Drug _____	Dose/ Frequency _____	Drug _____	Dose/ Frequency _____
Drug _____	Dose/ Frequency _____	Drug _____	Dose/ Frequency _____

\_\_\_ I take no medications or other supplements as listed.

### ALLERGIES

Name _____	Reaction You Had _____
Name _____	Reaction You Had _____
Name _____	Reaction You Had _____

\_\_\_ I have no known drug allergies

**SOCIAL HISTORY**

(Circle your best response)

Exercise Do you exercise? ..... Y N

How many minutes per week? \_\_\_\_\_ min

Diet Are you dieting? Y N If yes, are you on a physician prescribed medical diet? ..... Y N

Number of meals you eat in an average day? \_\_\_\_\_

Rank salt Intake HI Med Low Rank fat intake Hi Med Low

Caffeine \_\_\_ None \_\_\_ Coffee \_\_\_ Tea \_\_\_ Cola Number of cups/cans per day? \_\_\_\_\_

Alcohol Do you drink alcohol? ..... Y N

If yes, what kind? \_\_\_\_\_ How many drinks per week? \_\_\_\_\_

Are you concerned about the amount you drink? ..... Y N

Have you considered stopping? ..... Y N

Have you ever experienced blackouts? ..... Y N

Are you prone to "binge" drinking? ..... Y N

Do you ever drive after drinking? ..... Y N

Tobacco Do you use tobacco? Y N Number of years usage \_\_\_\_\_ Previous tobacco user – Year quit \_\_\_\_\_

\_\_\_ Cigarettes – pks/day \_\_\_\_\_ or pks/week \_\_\_\_\_ Chew - #/day \_\_\_\_\_ Pipe - #/day \_\_\_\_\_ Cigar - #/day \_\_\_\_\_

COVID Have you had COVID? Y N When? \_\_\_\_\_ Have you had the COVID vaccine? Y N

If yes, what manufacturer? \_\_\_\_\_ How many boosters have you had? \_\_\_\_\_

Drugs Do you currently use recreational or street drugs? ..... Y N

Have you ever given yourself street drugs with a needle? ..... Y N

Sex Are you sexually active? ..... Y N

If yes, are you and your partner trying for a pregnancy? ..... Y N

If not trying for a pregnancy, list contraceptive or barrier used: \_\_\_\_\_

Do you have discomfort during intercourse? ..... Y N

Illness related to Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem.

Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to

Speak with your provider about your risk of this illness? ..... Y N

Mental Health Is stress a major problem for you? ..... Y N

Do you feel depressed? ..... Y N

Do you panic when stressed? ..... y N

Do you have problems with eating or with your appetite? ..... Y N

Do you cry frequently? ..... Y N

Have you ever attempted suicide? ..... Y N

Have you ever seriously thought about hurting yourself? ..... Y N

Do you have trouble sleeping? ..... Y N

Have you ever been to see a counselor? ..... Y N

**PERSONAL SAFETY**

Do you live alone? ..... Y N

Do you have frequent falls? ..... Y N

Do you have vision or hearing loss? ..... Y N

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? Y N

How often do you have sun exposure? \_\_\_\_ Occasionally \_\_\_\_ Frequently \_\_\_\_ Rarely

Have you even experienced a sunburn? ..... Y N

How often do you wear a seatbelt? \_\_\_\_ Occasionally \_\_\_\_ Frequently \_\_\_\_ Always

**THESE QUESTIONS ARE FOR WOMEN ONLY**

Age at onset of menstruation: \_\_\_\_\_ Date of last menstruation: \_\_\_\_\_ Period every \_\_\_\_\_ days

Heavy periods, irregularity, spotting, pain, or discharge? ..... Y N

Number of pregnancies: \_\_\_\_\_ Number of live births: \_\_\_\_\_

Are you pregnant or breastfeeding? ..... Y N

Have you had a D&C, hysterectomy, or Cesarean? ..... Y N

Any urinary tract, bladder, or kidney infections within the last year? ..... Y N

Any blood in your urine? ..... Y N

Any problems with control of urination? ..... Y N

Any hot flashes or sweating at night? ..... Y N

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? ..... Y N

Do you perform monthly breast self-exams? ..... Y N

Have you experienced any recent breast tenderness, lumps, or nipple discharge? ..... Y N

Date of last papsmear or pelvic exam: \_\_\_\_\_

**THESE QUESTIONS ARE FOR MEN ONLY**

Do you usually get up to urinate during the night? ..... Y N

Do you feel pain or burning with urination? ..... Y N

Any blood in your urine? ..... Y N

Do you feel burning discharge from penis? ..... Y N

Has the force of your urination decreased? ..... Y N

Have you had any kidney, bladder, or prostate infections within the last 12 months? ..... Y N

Do you have any problems emptying your bladder completely? ..... Y N

Any difficulty with erection or ejaculation? ..... Y N

Any testicle pain or swelling? ..... Y N

Date of last prostate and rectal exam: \_\_\_\_\_

