<b>Argyle Family Prac</b>	tice
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## **HEALTH HISTORY QUESTIONNAIRE**

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Las	st, First, M.I.):		M 15 - According to the color of the color o		■ M	□F	DOB:	
Marital s	tatus: 🔲 Sin	gle  Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Wi	dowed	
Previous	or referring d	octor:			Date of la	ast phys	sical exam:	
							The second secon	
1 1 1 1 1 1 1 1			PER	SONAL HEAL	TH HISTORY		And the second s	
Childhoo	d illness:	 ☐ Measles ☐ Mump	s 🗆 Rubella	☐ Chickenpox	☐ Rheumatic	Fever	□ Polio	
Immuniz	ations and	☐ Tetanus	gr transcription in progression to the first statute		☐ Pneum	nonia		
dates:		☐ Hepatitis		The second secon	☐ Chicke	npox		
		☐ Influenza			☐ MMR A	Measles, Mu	mps, Rubella	
List any	medical proble	ems that other doc	tors have dia	gnosed	- 10 to the total of the total			
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Other ho	spitalizations		y garage gar ing ang again ang it tao kahand		en l'agric par a consergent manifelà de l'alternative			
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<u> </u>			CONTROL OF THE PROPERTY OF THE	processor and a recommendation of the second				
Have vo	u over had a h	lood transfusion?					☐ Yes ☐	No

Please turn to next page

List your pre	escribed drugs and over	-the-counter drugs	, such as vitamins and	inhalers								
Name the Dru	ıg	Strength	mpani er den sama samana - er mandrishinda arenda en	Frequency Taken	]			trois advisors place				
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			Control of the Contro			******************						
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Allergies to 1	medications		**************************************	· · · · · · · · · · · · · · · · · · ·								
Name the Dru	g	Reaction Y	ou Had	entenamente libros fram mantena e en minera e en minera en gran de en			• • • • • • • • • • • • • • • • • • • •					
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		HEALTH H	ABITS AND PERSON	AL SAFETY				· ·				
	ALL CHECTTONS CONTAIN	WED IN THE OHECT	ONNIATOR ADE OPTIONIAL	AND WILL DE VERT CTRICTLY	CONCIDENTIA							
			ONNAIRE ARE OPTIONAL	AND WILL BE KEPT STRICTLY	CONFIDENTIA	\L. 						
Exercise		Sedentary (No exercise)										
		Mild exercise (i.e., climb stairs, walk 3 blocks, golf)										
		Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)										
Diet	Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)  Are you dieting?  Yes  No											
Diet				+ = -								
		If yes, are you on a physician prescribed medical diet?  # of meals you eat in an average day?										
	Rank salt intake	□ Hi	☐ Med	Low								
	Rank fat intake		☐ Med	Low								
Caffeine	□ None	☐ Coffee	☐ Tea	Cola		**************************************	·					
Carronic	# of cups/cans per da					***************************************						
Alcohol	Do you drink alcohol?				П	Yes		No				
	If yes, what kind?		tradit value (e. m. in 1994) republicad abblanco appropriate a republicada de la companya de la	MILEONOMO, CHEC. 10 C. 12 CHI, MICH. ST., E., AND CHING DE C. VICENIA (MICH. MICH. M			<u>.                                    </u>					
		How many drinks per week?										
		Are you concerned about the amount you drink?										
	Have you considered		Yes		No							
	Have you ever experi	Have you ever experienced blackouts?										
	Are you prone to "binge" drinking?							No				
	Do you drive after dri	Do you drive after drinking?										
Tobacco	Do you use tobacco?					Yes		No				
	☐ Cigarettes – pks./	day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigar	s - #/c	lay					
	# of years	☐ Or year quit		and an experience of the second control of t								
Drugs	Do you currently use	recreational or street	drugs?			Yes		No				
	Have you ever given	yourself street drugs	with a needle?	The company of the co		Yes		No				

								-p		
Sex	Are you sexu	ually active?					Yes		No	
	If yes, are yo		Yes		No					
	If not trying									
	Any discomfo	Any discomfort with intercourse?								
	problem. Ris	Illness related to the 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?								
Personal	Do you live a		Yes		No					
Safety	Do you have	Do you have frequent falls?								
	Do you have	Do you have vision or hearing loss?								
	ļ	an Advance Directive and	d/or Living Will?	ng a gang ganggan yang napana tandamban bir di Aldrid 199 49	,		Yes		No	
		ke information on the pre					Yes		No	
	Physical and the form of v	/or mental abuse have als	so become major public health issues vior or actual physical or sexual abus	s in this country. Thi se. Would you like to	s often takes discuss this		Yes		No	
			FAMILY HEALTH HISTORY							
*.:	AGE	SIGNIFICANT HEAL	TH PROBLEMS	AGE	SIGNIFICANT I	HEAL.	TH PR	OBLE	MS	
Father			Children	□ M □ F						
Mother				□ M □ F						
Sibling	□ M □ F			□ M □ F	COMMON TO A CASE OF BANK BY THE WAY				. p.,,	
	□ M □ F			□ M						
	□ M		Grandmother  Maternal							
	☐ F ☐ M		Grandfather				<b></b>			
	☐ F ☐ M		Maternal  Grandmother							
	☐ M ☐ F		Paternal			- · ·				
	□ M □ F		Grandfather  Paternal							
			MENTAL HEALTH							
Is stress a m	naior problem for	you?		annianian ing tang arawa ana anakananah ali da a na anakanan			Yes		No	
Is stress a major problem for you?  Do you feel depressed?									No	
Do vou feel		· Company department of the second of the se					Yes			
			annum manada da da bara da la sang da taya na afarah. Na afara 17 - ann agan dan 18 - an afara					$+\equiv$	No	
Do you panio	depressed? when stressed?	ating or your appetite?				_	Yes			
Do you panio	depressed? when stressed? problems with ea						Yes Yes		No	
Do you panio Do you have Do you cry fi	depressed? when stressed? problems with ea	ating or your appetite?					Yes Yes		No No	
Do you panio Do you have Do you cry fi Have you ev	depressed?  when stressed?  problems with earequently?  er attempted suice	ating or your appetite?	?				Yes Yes Yes		No No No	
Do you panio Do you have Do you cry fi Have you ev Have you ev	depressed?  when stressed?  problems with earequently?  er attempted suice	ating or your appetite? dide? ght about hurting yourself	?				Yes Yes Yes Yes Yes		No No No No	

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		WOMEN ONLY							
Age at onset of menstruation:		and an order of the second of		·· 40 vo 4					
Date of last menstruation:		The second section of the second seco							
Period every days									
Heavy periods, irregularity, spotting, pain, or discharge?									No
Number of pregnancies Number of live births									
Are you pregnant or breastfeeding?									No
Have you had a D&C, hysterectomy, or Cesare		Yes		No					
Any urinary tract, bladder, or kidney infections within the last year?									No
Any blood in your urine?		e nye via vyanetini miyaniyan e verqa mendiya a alaka da ayen e e e e e e e e e e e e e e e e e e	**************************************	danie ira	Marie III, Karaki ng antagan ingganira, pagamana ang ataung ang ataungga		Yes		No
Any problems with control of urination?	ME 40 -11 Planes 4801	HERRING AREA AND AND AND AND AND SERVED SHEET SHEET AND	MT - 1874 - 1 MM - 1886 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	******			Yes		No
Any hot flashes or sweating at night?		e de didundo hallificialistica al allificial de debeno, araqquaranga			COLUMN TO THE RESIDENCE OF COLUMN THE COLUMN		Yes		No
Do you have menstrual tension, pain, bloating,	, irritabil	ity, or other symptoms at or arou	nd time of per	iod?			Yes		No
Experienced any recent breast tenderness, lun	ps, or r	nipple discharge?					Yes		No
Date of last pap and rectal exam?	***************************************				,		~,44-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-	-/	
		THE STATE OF THE S							ę gara
		MEN ONLY	e de la desta de la desta de la composição					<u> 1. j. j.</u>	
Do you usually get up to urinate during the night?							Yes		No
If yes, # of times								<del></del>	
Do you feel pain or burning with urination?							Yes		No
Any blood in your urine?							Yes		No
Do you feel burning discharge from penis?							Yes		No
Has the force of your urination decreased?							Yes		No
Have you had any kidney, bladder, or prostate	infection	ns within the last 12 months?					Yes		No
Do you have any problems emptying your black	ider con	npletely?					Yes		No
Any difficulty with erection or ejaculation?							Yes		No
Any testicle pain or swelling?							Yes		No
Date of last prostate and rectal exam?									
Check if you have, or have had, any symptom	a in the	OTHER PROBLEMS	area and brief		valoio.				
Check if you have, or have had, any symptom	3 K1 U)C	Thomas areas to a significant de	gree and orien	.y C	pient.				
Skin		Chest/Heart			Recent changes in:				-
☐ Head/Neck		Back			Weight				
☐ Ears		Intestinal			Energy level				
☐ Nose		Bladder			Ability to sleep				
☐ Throat		Bowel			Other pain/discomfort	:			
☐ Lungs		Circulation							