Today's Date: _____/_____/_____

HEALTH HISTORY QUESTIONNAIRE

All answers to questions contained in this questionnaire are strictly confidential.

Name: *(Last, First, M.I.)*	☐ **M** ☐ **F**	**DOB** _____/_____/_____ **Marital Status:** _____
Current Doctor:	**Phone #:**	**Date of Last Physical Exam:** _____

CURRENT HEALTH HISTORY

List Any Current Medical Problems That Are Being Evaluated and/or Treated by Your Doctor:

Do you have any taste or smell disorders? ☐ Yes ☐ No

Have you tested positive for COVID-19 in the past 4 weeks? ☐ Yes ☐ No

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Name of Drug	Strength	Frequency Taken

Allergies to Medications, Foods, Pollens, etc:

Name the Drug or Item	Reaction You Had (e.g. rash, hives, itching, runny nose, respiratory difficulty, swelling)

PAST HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

List Any Past Medical Problems That Doctors Have Diagnosed:

Surgeries:

Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital

Have you ever had a blood transfusion?..... ☐ Yes ☐ No

LIST OF DISEASES/PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin _____
☐ Head/Neck_____
☐ Ears _____
☐ Nose _____
☐ Throat _____
☐ Lungs_____
☐ Back _____
☐ Bone disease _____
☐ Bone fracture_____
☐ Osteoporosis _____

☐ Chest/Heart _____
☐ Circulation__ _____
☐ Intestinal _____ _____
☐ Bladder _____
☐ Bowel _____
☐ Arthritis _____
☐ Thyroid disease_____
☐ Diabetes_____ _____
☐ Abnormal glucose tolerance____
☐ Abnormal blood sugar_____

☐ Elevated blood cholesterol_____
☐ Abnormal blood pressure_____

Recent Changes In:

☐ Weight _____
☐ Energy Level _____
☐ Appetite _____
☐ Ability to Sleep _____

Other Pain/Discomfort:

_____
_____

FAMILY HEALTH HISTORY

List all diseases which tend to occur in your blood relatives (parents, brothers, sisters, children). Especially note such illnesses as diabetes, high blood pressure, heart disease, high cholesterol levels, thyroid problems.

PARENTS:

SIBLINGS:

CHILDREN:

GRANDPARENTS:

HEALTH HABITS AND PERSONAL SAFETY

Exercise and Activity Level:

Are you able to do light chores, meal preparation, or climb 10 steps without developing shortness of breath or chest pain and without assistance of others? ..... ☐ Yes ☐ No

What is your usual activity level (check one): ☐ Sedentary (No exercise)
☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
☐ Occasional Vigorous Exercise (i.e., work or recreation, < 4 times/week for 30 min.)
☐ Regular Vigorous Exercise (i.e., work or recreation 4 or more times/week for 30 min)

Do you participate in exercise or a sports program? ..... ☐ Yes ☐ No
Please describe:_____
Describe activities during typical day_____

Diet:

Are you dieting? ..... ☐ Yes ☐ No
If yes, are you on a physician prescribed medical diet? ..... ☐ Yes ☐ No
Have you lost weight? How much weight_____ over what time period_____
# of meals you eat in an average day?_____ # Snack/day_____

Caffeine:

☐ None ☐ Coffee # of Cups/day? _____ ☐ Tea # of Cups/Cans per day? _____
☐ Cola # of Cups/Cans per day? _____

Alcohol:

Do you drink alcohol? ..... ☐ Yes ☐ No
If yes, what kind?_____ How many drinks per week? _____

Tobacco:

Do you currently use tobacco? ..... ☐ Yes ☐ No
☐ Cigarettes - Pks/day_____ ☐ Chew - #/day _____ ☐ Pipe - #/day _____
☐ Cigars - #/day _____ ☐ # of Years _____
Have you used tobacco in the past? ..... ☐ Yes ☐ No
☐ # Years used _____ ☐ # Years since you quit _____

Education and Occupation:

Please indicate highest education level. ☐ < High School ☐ High School Graduate
☐ Technical/Trade School ☐ College Graduate ☐ Postgraduate or Professional School
What is your occupation?_____

WOMEN ONLY

Age at onset of menstruation: _____ Date of last cycle's menstruation: _____/_____/_____
Age at onset of menopause:_____ Date of last menstruation: _____/_____/_____
How long is your cycle? _____ days. What is the range of your cycle length? _____
Have you had 1 cycle per month for the past 12 months? ..... ☐ Yes ☐ No
Do you consider your cycle to be regular? .... ☐ Yes ☐ No
Do you have heavy periods, irregularity, spotting, pain or discharge? ..... ☐ Yes ☐ No
Number of pregnancies _____ Number of live births _____
Are you pregnant or breastfeeding? ..... ☐ Yes ☐ No
Do you take any birth control or estrogen medication? (please list in medication section)..... ☐ Yes ☐ No
Have you had a D&C, hysterectomy or cesarean?..... ☐ Yes ☐ No
Any urinary tract, bladder, or kidney infections within the last year? ..... ☐ Yes ☐ No
Any blood in your urine? ..... ☐ Yes ☐ No
Any hot flashes or sweating at night? ..... ☐ Yes ☐ No
Do you have menstrual tension, pain, bloating, or irritability at or around time of period? ..... ☐ Yes ☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge? ..... ☐ Yes ☐ No
Date of last pap? _____/_____/_____ Date of last rectal exam? _____/_____/_____

MEN ONLY

Do you usually get up to urinate during the night? ..... ☐ Yes ☐ No If yes, # of times _____
Do you feel pain or burning with urination? ..... ☐ Yes ☐ No
Any blood in your urine? ..... ☐ Yes ☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months? ..... ☐ Yes ☐ No
Do you have any problems emptying your bladder completely? ..... ☐ Yes ☐ No
Any testicle pain or swelling? ..... ☐ Yes ☐ No
Date of last prostate exam? _____/_____/_____ Date of last rectal exam? _____/_____/_____

NUTRITONAL SUPPLEMENTS

During the last two months, have you taken any vitamins, minerals, or other nutritional supplements?
☐ Yes ☐ No

If Yes, place a check for the Number of Tablets and How Long Taken:

Nutritional Supplement	Number of Tablets					How Long Taken		
	1 - 3 per week	4 - 6 per week	1 per day	2 per day	3 + per day	0 - 3 mo	3 -12 mo	1 + yr
Multiple Vitamins One-a-day type								
Stress-tab type								
Therapeutic, Theragram								
Other: _____								
Other Supplements								
Vitamin A								
Beta - carotene								
Vitamin C								
Vitamin E								
Vitamin B6								
Calcium or Tums								
Fish Oil								
Calcium								
Soy protein								
Whey protein								
Protein supplement								
Other, including Herbals (specify)								
Other Antioxidants (specify)								

USAUDIT Questionnaire

Instrument USAUDIT

Instructions: Alcohol can affect your health, medications, and treatments, so we ask patients the following questions. Your answers will remain confidential. Place an X in one box to answer. Think about your drinking **in the past year.** A drink means one beer, one small glass of wine (5 oz.), or one mixed drink containing one shot (1.5 oz.) of spirits.

QUESTIONS	0	1	2	3	4	5	6	Score
1. How often do you have a drink containing alcohol?	Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	Daily	
2. How many drinks containing alcohol do you have on a typical day you are drinking?	1 drink	2 drinks	3 drinks	4 drinks	5-6 drinks	7-9 drinks	10 or more drinks	
3. How often do you have X (5 for men; 4 for women & men over age 65) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	Daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily			
5. How often during the past year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily			
6. How often during the past year have you needed a drink first thing in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily			
7. How often during the past year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily			
8. How often during the past year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily			
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the past year		Yes, during the past year			
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking and suggested you cut down?	No		Yes, but not in the past year		Yes, during the past year			
							Total	