NORTH LIBERTY FAMILY HEALTH CENTRE, PC

Health History Questionnaire

Name Date of Birth Date

Education ______ years of high school	_______ years of college	________ years of post grad.

Occupation	Date of last physical examination ____________________
All previous occupations	Please list all symptoms which are current
	1
Birthplace	2
Single_______ Separated _______	3
Married _______ Partnered _______	4
Divorced _______	5
Widow (er) _______	Routine checkup-no problems ____________________

NOTE: *This is a confidential record of your medical history and will be kept in this office. Information obtained here will not be released to any person except when you have authorized us to do so.*

FAMILY HISTORY:	If Living Age	Health	If Deceased Age at Death	Cause	Has any blood relative ever had:	Please circle Yes or No	Who
Father					Allergies	Yes No	
Mother					Asthma	Yes No	
Brother or Sister					Arthritis	Yes No	
1					Glaucoma	Yes No	
2					Cancer	Yes No	
3					Tuberculosis	Yes No	
4					Diabetes	Yes No	
5					Heart Trouble	Yes No	
6					High Blood Pressure	Yes No	
Husband or Wife					Stroke	Yes No	
Son or Daughter					Epilepsy	Yes No	
1					Substance Abuse	Yes No	
2					Depression	Yes No	
3					Emotional Problems	Yes No	
4					Suicide	Yes No	
5					Kidney Trouble	Yes No	
6					Thyroid Disease	Yes No	

PERSONAL HISTORY Circle any of the items listed below that apply to you:

Chicken Pox
Whooping Cough
Pneumonia
Rheumatic fever or any heart problem
Arthritis/Rheumatism
Any bone or joint disease
Thyroid diseases
Polio or Meningitis
Recurrent Bladder or Kidney infection
Gonorrhea, Syphilis, or Genital Herpes
Anemia
Yellow Jaundice or Hepatitis
Epilepsy
Migraine headaches
Tuberculosis
Mononucleosis
Diabetes
Cancer
High blood pressure
Low blood pressure
Anxiety or Depression
Hay fever
Asthma
Hives
Eczema
Frequent infections or boils

Any other diseases:
____
____

ALLERGIES: Are you allergic to any:
Medication? ____________________
Food? ____________________
Latex? ____________________
Other? ____________________

INJURIES: Have you had any:
Broken or cracked bones
Recent sprains
Severe lacerations
Dislocations
Concussion or head injury
Blood or plasma transfusions

WEIGHT:
Now ____________________
1 year ago ____________________
Desired ____________________

HABITS:
Use of seat belts ____________________
Alcohol use:
Never Past Current
# of drinks per week ____________
# of drinks per month ____________
Illicit drug use:
Never Past Current
Substance used ____________________
Tobacco use:
Never Past Current
Cigars Chewing tobacco
Cigarettes Pipe
years of use ______________
per day ____________________
Quit date ____________________

DIET:
____

EXERCISE: Type
____

Frequency, distance, or amount
____

PLEASE TURN OVER ↓

Name Date of Birth Date

HOSPITALIZATIONS: List all hospitalizations (for illness or surgery) beginning with the most recent.

Date	Reason	Hospital	M.D.

Circle any of the items listed below that apply to you currently

SYSTEM REVIEW:

Any eye disease, injury, impaired sight
Any ear disease, injury, impaired hearing
Any trouble with nose, sinuses, mouth, throat
Problems with your teeth
Fainting spells
Convulsions or seizures
Paralysis or numbness
Dizziness
Frequent or severe headaches
Difficulty remembering or concentrating
Difficulty sleeping
Frequent crying spells
Difficulty related to work or family problems
Thoughts about committing suicide
Enlarged glands
Enlarged thyroid or goiter
Skin problems
Lumps in your breasts
Chronic or frequent cough
Chest pain or angina pectoris
Spitting up of blood
Night sweats
Shortness of breath
Palpitation or fluttering heart
Heart murmur
Swelling of hands, feet, or ankles
Extreme tiredness or weakness
Varicose veins
Kidney disease or stones
Bladder disease
Protein, sugar, pus, blood in urine
Difficulty urinating
Get up at night to urinate
Abnormal thirst
Stomach trouble or ulcer
Indigestion or heartburn
Recent change in appetite or eating habits
Liver or gall bladder disease
Colitis or other bowel disease
Hemorrhoids or rectal bleeding
Constipation or diarrhea
Recent change in bowel habits or stools
Black bowel movements
Stiff, painful, or swollen joints
Sexual difficulties

X-RAYS: Have you ever had x-rays/other imaging:

Chest Stomach
Back Colon
Extremities Gall Bladder
Other ____________________

EKG: Have you had:

Electrocardiogram Yes No
Stress test Yes No

IMMUNIZATIONS: Have you had:

Measles and mumps immunization Yes No
Tetanus (date of last shot) ____________________
Hep A immunization Yes No
Hep B immunization Yes No
Influenza vaccine within last year Yes No
Pneumovax (date of last shot) ____________________
Shingles vaccine (date of last shot) ____________________

Present medications: List all prescription drugs that you are presently taking: (including over the counter medication)

____
____
____
____
____
____
____

MEN ONLY Have you ever had swelling of or lumps on testicles? Yes No
Current method of birth control ____________________

WOMEN ONLY

Menstrual History:
Age at onset ____________________
Date of last period ____________________
Cycle (from start to start) ________ days
Usual duration of flow is ________ days
Flow is: heavy medium light
Pain or cramps
Periods are irregular

Have had vaginal infections or frequent discharge Yes No
Have taken birth control pills or used an IUD Yes No
Have had abnormal PAP Yes No
Date of last PAP ____________________
Current method of birth control ____________________

Pregnancies: total number ____________________
How many children born alive? ____________________
How many stillbirths? ____________________
How many premature? ____________________
How many Cesarean sections? ____________________
How many miscarriages? ____________________
How many abortions? ____________________

Physician's Signature Date reviewed