Date of appointment _____/_____/__________ (mm/dd/yyyy)

**Please fill this form out as completely as possible and bring this to your appointment.**

If you have filled out this form previously, please enter any changes in your health history that have occurred since your last visit.

### Past Medical History

(Please check any medical problems that you have had in the past)

- [ ] Abnormal pap smear
- [ ] Alcoholism
- [ ] Allergies
- [ ] Anemia
- [ ] Anxiety
- [ ] Asthma
- [ ] Blood transfusion
- [ ] BPH (benign prostatic hyperplasia)
- [ ] Cancer
- [ ] Cataracts
- [ ] Clotting disorder
- [ ] Colonic adenoma
- [ ] Concussion
- [ ] Other (list)

### Past Surgical History

(Check any surgeries you have had and the date of surgery if you know it)

- [ ] Appendectomy
- [ ] Bariatric surgery
- [ ] Brain surgery
- [ ] Breast surgery
- [ ] CABG (bypass)
- [ ] Cesarean section
- [ ] Cholecystectomy (gall bladder removal)
- [ ] Colon surgery

Additional Information:
**Health History Questionnaire – Family Medicine – 11 Years of Age and Older**

**Family History**
Check below to report problems your family members have had. Please state the age when they had the problem if you know it. Please enter the name of the person in the blank.

- Checkadopter (unknown/incomplete family history).

<table>
<thead>
<tr>
<th>Condition</th>
<th>Mother</th>
<th>Father</th>
<th>Sister</th>
<th>Brother</th>
<th>Daughter</th>
<th>Son</th>
<th>Other (list)</th>
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<td>Birth defects</td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Colon cancer</td>
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<tr>
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<tr>
<td>Depression</td>
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<td>Mental illness</td>
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<tr>
<td>Stroke</td>
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<tr>
<td>Thyroid disease</td>
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<td>Other (list)</td>
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<td>Other (list)</td>
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<tr>
<td>Alive (Yes, No or N/A=Not Applicable)</td>
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</tbody>
</table>
For Female Patients Only:

Menstrual History

Age when period started _____ years  □ Period has not yet started. Please skip to next section.
Period cycle _____ days
Period duration _____ days
Period pattern:  □ Regular  □ Irregular
Menstrual flow:  □ Light  □ Moderate  □ Heavy
Menstrual control method:
□ Panty liner  □ Thin pad  □ Maxi pad  □ Hospital pad  □ Tampon  □ Other (specify) ______________

How often do you change your menstrual control method? Every _____ hours.

Dysmenorrhea (painful menstruation):  □ None  □ Mild  □ Moderate  □ Severe

Dysmenorrhea symptoms (please describe): ________________________________________________________________

Age when menopause started _____ years
Date of last pap smear ________   History of abnormal pap smears?  □ No  □ Yes   If yes, what was the abnormality (if known)? ____________________________________________________________

If over age 40, date of last mammogram (approximate) __________

Pregnancy History:
□ Never pregnant □ History of pregnancy □ Currently pregnant

Number of pregnancies (G) _____
Number of deliveries (P) _______ Number of preterm deliveries (<37 weeks) _______ Full term deliveries ______
Multiple birth deliveries _______ Miscarriages/abortions _______ Living children ______

Comments (pregnancy complications): __________________________________________________________________________

Social History

Substance and Sexual Activity

Alcohol

Do you ever drink alcohol?  □ Yes – if yes, complete all alcohol related questions
□ No – if no, skip to next section

Please indicate the quantity per week of each:

Glasses of wine: ___________ Can/bottles of beer: ___________
Shots of liquor: ___________ Drinks containing .5 oz of alcohol: ___________

Have people ever felt like you should cut down on drinking?  □ Yes  □ No
Have people annoyed you by criticizing your drinking?  □ Yes  □ No
Have you ever felt guilty about your drinking?  □ Yes  □ No
Have you ever had an “eye-opener” (an alcoholic drink first thing in the morning) to help you feel better?  □ Yes  □ No
Drugs and tobacco

Do you use drugs?  ☐Yes  ☐No
If you use drugs, how many times per week? __________
What type(s) of drugs do you use? __________________

Check one of the following about smoking tobacco:
☐Never smoked  ☐Exposed to second hand smoke  
☐Former smoker  ☐Smoke some days  ☐Smoke everyday
If you smoked or used to smoke, how many packs do or did you smoke per day? ________________
How many years did you smoke / have you smoked? ________________
If you quit smoking, when did you quit? ________________

Check one of the following about smokeless tobacco:
☐Never used  ☐Former user  ☐Current user
If you quit smokeless tobacco, when did you quit? ________________
Are you ready to quit smoking or using smokeless tobacco? __________________

Do you use e-cigarettes?
☐No  ☐Used in the past  ☐Not presently  ☐Occasionally  ☐Daily

Sexual activity

Are you sexually active?  ☐Yes  ☐No  ☐Not currently
If yes, are your partner(s):  ☐Male  ☐Female  ☐Both

Type of birth control / protection (check all that you use):
☐Not having sex (abstinence)  ☐Condom  ☐Injection  ☐IUD (intrauterine device)
☐Oral contraceptives (Pill)  ☐Partner vasectomy  ☐Patch  ☐Post-Menopausal
☐Vasectomy  ☐None  ☐Other (specify):

Do you have a new sexual partner? __________

Lifestyle

On average, how many days per week do you engage in moderate to strenuous exercise?
☐1 day  ☐2 days  ☐3 days  ☐4 days  ☐5 days  ☐6 days  ☐7 days
On average, how many minutes do you engage in exercise at this level?
☐0 min  ☐10 min  ☐20 min  ☐30 min  ☐40 min  ☐50 min  ☐60 min  ☐70 min
☐80 min  ☐90 min  ☐100 min  ☐110 min  ☐120 min  ☐130 min  ☐140 min  ☐150+ min
Safety
Do you have a gun at home? ☐ Yes ☐ No

Socioeconomic
Employment
Occupation: ___________________________________________
Employer: ___________________________________________

Demographics
Marital status: ☐ Divorced ☐ Legally separated ☐ Married ☐ Significant other
☐ Single ☐ Widow ☐ Unknown ☐ Other (specify): ____________________________
Spouse name: ___________________________________________
Number of children: _______________________________________
Years of education: _______________________________________

Review of Systems • Please circle which symptoms you have currently.

<table>
<thead>
<tr>
<th></th>
<th>General</th>
<th>Head</th>
<th>Eye</th>
<th>Ear</th>
<th>Nose</th>
<th>Mouth/throat</th>
<th>Lung</th>
<th>Heart</th>
<th>Gastrointestinal</th>
<th>Genitourinary</th>
<th>Musculoskeletal</th>
<th>Neurologic</th>
<th>Skin</th>
<th>Psychiatric</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>fever</td>
<td>decreased/no energy</td>
<td>loss appetite</td>
<td>unintended weight gain/loss</td>
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<td>none</td>
<td>none</td>
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</tr>
<tr>
<td>Head</td>
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<td>injury</td>
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<tr>
<td>Eye</td>
<td>visual change</td>
<td>crossed</td>
<td>discharge</td>
<td>redness</td>
<td>puffiness</td>
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<tr>
<td>Ear</td>
<td>difficulty with hearing</td>
<td>pain</td>
<td>discharge</td>
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</tr>
<tr>
<td>Nose</td>
<td>runny nose</td>
<td>nasal congestion</td>
<td>nose bleed</td>
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<tr>
<td>Mouth/throat</td>
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<td>difficulty swallowing</td>
<td>dental problems</td>
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<td>none</td>
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<td>none</td>
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<td>none</td>
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<tr>
<td>Lung</td>
<td>shortness of breath</td>
<td>coughing</td>
<td>chest pain</td>
<td>wheezing</td>
<td>sputum</td>
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<tr>
<td>Heart</td>
<td>pale cyanosis</td>
<td>chest pain</td>
<td>leg swelling</td>
<td>faint</td>
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<tr>
<td>Gastrointestinal</td>
<td>abdominal pain</td>
<td>nausea</td>
<td>vomiting</td>
<td>diarrhea</td>
<td>constipation</td>
<td>distention</td>
<td>blood in stool</td>
<td>black/tarry stool</td>
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<tr>
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<td>urine retention</td>
<td>incontinence</td>
<td>difficulty urinating</td>
<td>blood in urine</td>
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<td>joint swelling</td>
<td>difficulty in moving</td>
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Printed name of person who completed this form ____________________________ 

Date __________/________/________ (mm/dd/yyyy)