Abundant Health Family Practice

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Phone# 520-326-1457 Fax# 520-326-1464

Today' s Date:

HEALTH HISTORY QUESTIONNAIRE

All information contained in this questionnaire is strictly confidential and will become part of your medical record. No one will have access to it without your permission.

Name *(First, M.I. Last):*	☐ Male ☐ Female	**DOB:**
Previous Primary or Referring provider name:	**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

LIST OF MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED:

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs (such as vitamins, herbals, and inhalers

Name the Drug	Strength	Frequency Taken

Please turn over sheet and continue...

PATIENT NAME_____ DATE_____

Allergies to medications **Name the Drug**	**Reaction You Had (IE: rash, swelling, nausea, etc.)**
Have you ever had a blood transfusion?	☐ Yes ☐ No

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Immunizations Dates received:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR (*Measles, Mumps, Rubella)*

SOCIAL HABITS, PERSONAL SAFETY, AND PREVENTAIVE HEALTH TESTING						
ALL INFORMATION CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.						
Occupation	Job Title: Employer:					
Education	☐ Less than 12th ☐ High School Graduate ☐ College Degree ☐ Post Graduate					
Marital Status	☐ Married ☐ Single ☐ Domestic Partner					
Sexual Orientation	☐ Heterosexual ☐ Homosexual Male ☐ Lesbian ☐ Bisexual ☐ Trans-sexual ☐ A-sexual					
Sexual Activity	☐ Sexually Active ☐ Abstinent ☐ Monogamous ☐ Multiple partners					
	If sexually active – Are you trying to become pregnant?				☐ Yes	☐ No
	Do you use condoms every time you have intercourse?				☐ Yes	☐ No
	Any discomfort with intercourse?				☐ Yes	☐ No
	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?				☐ Yes	☐ No
Exercise	☐ Sedentary (No exercise) ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e. 2-3 x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., 4x/week for 30 minutes or more)					
_____	☐ Regular diet ☐ Vegetarian - Type: ☐ Other diet					
Diet	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Stress Level	☐ Low	☐ Medium	☐ High	☐ Extremely High		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind? How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No

Please go to next page and continue...

PATIENT NAME_____ DATE_____

Tobacco	Do you use tobacco? ☐ Smoke ☐ Chew ☐ Both			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ If quit – What Year?			
Personal Safety	Do you currently use recreational or street drugs? (IE: Marijuana, Cocaine, Methamphetamine, Heroin)			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
	Do you have guns in your home?			☐ Yes	☐ No
	Do you regularly use seatbelts?			☐ Yes	☐ No
	Do you regularly use sunscreen?			☐ Yes	☐ No
	Do you have a smoke alarm in your home?			☐ Yes	☐ No
	Are you exposed to passive smoke (others who smoke in home)?			☐ Yes	☐ No
	Do you live alone?			☐ Yes	☐ No
	Are you able to care for yourself?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Are you exposed to animals (IE: Dogs, cats, birds, ferrets, etc.)?			☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ No
	Physical and/or mental abuse has 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?			☐ Yes	☐ No

Preventative Heath Testing	
Rectal Prostate Exam or PSA ☐ Yes ☐ No Date of last exam:	Rectal Exam: ☐ Yes ☐ No Date of last exam:
Mammogram: ☐ Yes ☐ No Date of last exam:	Bone Density Scan: ☐ Yes ☐ No Date of last exam:
Colonoscopy: ☐ Yes ☐ No Date of last exam:	Pap smear: ☐ Yes ☐ No Date last exam:
Do you perform monthly self breast exams? ☐ Yes ☐ No	Abnormal results?

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** ***Maternal***		
	☐ M ☐ F		**Grandfather Maternal**		
	☐ M ☐ F		***Grandmother Paternal***		
	☐ M ☐ F		**Grandfather** *Paternal*		

GYNECOLOGICAL HISTORY (FEMALE PATIENTS ONLY)

Last Menstrual Cycle (Period): Date_____ Frequency of cycle? (IE: 28 – 32 days apart) _____

Days of flow per cycle: _____ Flow: ☐ light ☐ moderate ☐ heavy Age cycle started: _____

Birth control method used: ☐ None ☐ Rhythm ☐ Condoms ☐ Pill ☐ IUD ☐ Subdermal ☐ Partner Vasectomy ☐ Other

Are you menopausal? ☐ Yes ☐ No If yes, at what age did you go through menopause (stop menstruating)? _____

# of Pregnancies_____ Miscarriages _____ Abortions _____ Ectopic _____Multiple _____ Living children _____Your age at 1rst delivery _____

Please turn over sheet and continue...

PATIENT NAME_____ DATE_____

MENTAL HEALTH			
Is stress a major problem for you?	☐ Yes ☐ No	Do you feel depressed?	☐ Yes ☐ No
Do you panic when stressed?	☐ Yes ☐ No	Do you have problems with eating or your appetite?	☐ Yes ☐ No
Do you cry frequently?	☐ Yes ☐ No	Do you have trouble sleeping?	☐ Yes ☐ No
Have you ever been to a counselor?	☐ Yes ☐ No	Have you ever had a psychiatric evaluation?	☐ Yes ☐ No
So you ever cut as a form of coping?	☐ Yes ☐ No	If yes, areas used for cutting: ☐ Arms ☐ Wrists ☐ legs ☐ Abdomen ☐ Other	
Have you ever seriously thought about hurting yourself?	☐ Yes ☐ No	Have you ever attempted suicide?	☐ Yes ☐ No

OTHER PROBLEMS

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

☐ Visual Changes/Loss	☐ Shortness of breath	☐ Changes in muscle strength
☐ Head Injury	☐ Asthma or Emphysema	☐ Falling
☐ Headaches	☐ High blood pressure	☐ Hepatitis A, B or C
☐ Seizures	☐ Chest pain, heart attack	☐ Sexually Transmitted Infections
☐ Hearing Loss	☐ Constipation or Diarrhea	☐ Elevated cholesterol or glucose levels
☐ Nose Issues	☐ Difficulty controlling bowel or bladder	☐ Diabetes
☐ Throat Issues	☐ GYN problems	☐ Memory problems
☐ Thyroid disorder	☐ Cancer/Tumors/Cysts	☐ Difficulty with sleep
☐ Allergies	☐ Back Pain	☐ Childhood Illness - specify
☐ Recent Weight Changes	☐ Other pain:	☐ Other chronic health issues:

Please use the space below to share any other concerns:

PROVIDER'S COMMENTS

Please fill out forms completely, then give completed papers to the receptionist in order to complete your check in. Thank you! ☺

PATIENT NAME_____ DATE_____