Lake Road Family Medicine
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HEALTH HISTORY QUESTIONNAIRE

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

Name (Last, First, M.I.) ☐M ☐F			**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Previous or referring doctor:		Date of last physical exam:	
PERSONAL HEALTH HISTORY			
Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox Rheumatic Fever ☐ Polio			
Immunizations & dates:	☐ Tetanus	☐ Pneumonia	
	☐ Hepatitis	☐ Chickenpox	
	☐ Influenza	☐ MMR (Measles, Mumps, Rubella)	
List any medical problems that other doctors have diagnosed			

Surgeries		
Year	Reason	Hospital

Other Hospitalizations:		
Year	Reason	Hospital

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

List your prescribed drugs and over-the-counter medications, such as vitamins and inhalers		
Name the Drug	**Strength**	**Frequency Taken**

Allergies to Medications	
Name the Drug	**Reaction You Had**

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL					
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.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?				☐ Yes ☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes ☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ High	☐ Med	☐ Low	
	Rank fat intake	☐ High	☐ Med	☐ Low	
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 ever 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
Tobacco	Do you use tobacco?				☐ Yes ☐ No
	☐ Cigarettes- pks./day.	☐Chew-#/day.	☐ Pipe- #/day	☐Cigars-#/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?				☐ Yes ☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes ☐ No

WOMEN ONLY	
Age at onset of menstruation:	
Date of last menstruation:	
Period every_____ days	
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes ☐ No
Number of pregnancies_____ Number of live births_____	
Are you pregnant or breastfeeding?	☐ 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 urine?	☐ Yes ☐ No
Any problems with control of urination?	☐ Yes ☐ No
Any hot flashes or sweating at night?	☐ Yes ☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes ☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes ☐ No
Date of last pap and 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
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 infections within the last 12 months?	☐ Yes ☐ No
Do you have any problems with emptying your bladder completely?	☐ Yes ☐ No
Any difficulty with erection or ejaculation?	☐ Yes ☐ No
Any testicle pain or swelling?	☐ Yes ☐ No
Date of last prostate and rectal exam?	☐ Yes ☐ No

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

Sex	Are you sexually active?	☐ Yes ☐ No
	If yes, are you trying for a pregnancy?	☐ Yes ☐ No
	If not trying for a pregnancy list contraceptive method used:	
	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
Personal Safety	Do you live alone?	☐ Yes ☐ No
	Do you have frequent falls?	☐ Yes ☐ No
	Do you have vision or hearing loss?	☐ 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 have also become a major public health issue 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

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	

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
Have you ever attempted suicide?	☐ Yes ☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes ☐ No
Do you have trouble sleeping?	☐ Yes ☐ No
Have you ever been to a counselor?	☐ Yes ☐ No