HEALTH HISTORY QUESTIONNAIRE

HIGH LAKES Health Care

Patient Name: _____ **Patient DOB:** _____

Reason for Visit: _____

PAST MEDICAL HISTORY (*Please Check All That Apply*)			
☐ Abnormal PAP	☐ COPD / Emphysema	☐ Hepatitis	☐ Psoriasis
☐ Allergies	☐ Crohn's Disease	☐ High Blood Pressure	☐ Restless Leg Syndrome
☐ Anemia	☐ Depression	☐ High Cholesterol	☐ Rheum. Fever
☐ Anxiety	☐ Diabetes	☐ HIV/AIDS	☐ Rheumatoid Arthritis
☐ Asthma	☐ Diverticulosis	☐ Insomnia	☐ Seizure Disorder
☐ Atrial Fibrillation	☐ Eating Disorder: _____	☐ Kidney Disease	☐ Sleep Apnea
☐ Autoimmune Disease	☐ Eczema	☐ Kidney Stones	☐ Stroke
☐ Bipolar Disorder	☐ Epilepsy	☐ Liver Disease	☐ Thyroid Problems
☐ Bleeding Disorder	☐ GI Bleeding	☐ Macular Degeneration	☐ Tuberculosis
☐ Blood Clots (PE or DVT)	☐ Glaucoma	☐ Memory Loss / Dementia	☐ Ulcers: _____
☐ Blood Transfusion date(s):_____	☐ Gout	☐ Migraines	☐ Ulcerative Colitis
☐ Cancer**:**_____	☐ Heart Attack	☐ Multiple Sclerosis	☐ Urethral Problems
☐ Cataracts	☐ Heart Murmur	☐ Osteoarthritis	☐ Other: _____
☐ Chronic Back Pain	☐ Heart Failure	☐ Osteoporosis / Osteopenia	☐ Other:_____
☐ Coronary Artery Disease	☐ Hernia	☐ Pacemaker	☐ Other: _____
☐ Colon Polyps	☐ Herpes	☐ Parkinson's Disease	☐ Other:_____
		☐ Polio	☐ Other: _____

GYNECOLOGICAL HISTORY *(Females Only)*	
# of Pregnancies:	Date(s):
# of Live Births:	Date(s):
# of C-Sections:	Date(s):
Hormone Replacement Therapy: ☐ Yes ☐ No	Date(s):
If Sexually Active, Contraception Use: ☐ Yes ☐ No	Form:
Last PAP Smear / Pelvic Exam:	Result:

SURGERIES / HOSPITALIZATIONS	*Reason*	*Date / Location*
①		
②		
③		
④		

CURRENT MEDICATIONS *(List All Prescription and Over-The-Counter Medications, Supplements, CPAP and Oxygen)*

Medication	***Strength / Dose***	***Frequency Taken***
①		
②		
③		
④		
⑤		
⑥		
⑦		
⑧		
⑨		
⑩		

MEDICATION ALLERGIES	*Reaction*
①	
②	
③	

SOCIAL HISTORY	
Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Widowed ☐ Divorced	Occupation: _____
Highest level education: _____	
Do you use tobacco? ☐ Past (Quit: _____) ☐ Present ☐ Never	How many years of use? _____
Packs per day? ____ Cans per day? _____	Exposed to second hand smoke at home? ☐ Past ☐ Present ☐ Never
Do you use alcohol? ☐ Past (Quit: _____) ☐ Present ☐ Never	How many drinks per week? _____
Have you ever been treated for alcoholism? ☐ Yes ☐ No	
Do you exercise? ☐ Yes (Type: _____) ☐ No	Frequency? _____
Consume caffeine, tea, soda? ☐ Past ☐ Present ☐ Never	Recreational drug use? ☐ Past ☐ Present ☐ Never
If you ride a bike or motorcycle, do you wear a helmet? ☐ Yes ☐ No	Do you wear a seatbelt? ☐ Yes ☐ No
Are guns kept in your home? ☐ Yes ☐ No	If yes, is household aware of gun safety? ☐ Yes ☐ No

FAMILY HISTORY						
Relation	***Alive***	***Age***	***Significant Health Problems***			
Father	Y / N	____	☐ Depression ☐ Genetic Disease ☐ Heart Attack	☐ Stroke ☐ Autoimmune Disease ☐ High Blood Pressure	☐ Glaucoma ☐ Cancer:_____ ☐ Diabetes	☐ Osteoporosis ☐ Other: _____
Mother	Y / N	____	☐ Depression ☐ Genetic Disease ☐ Heart Attack	☐ Stroke ☐ Autoimmune Disease ☐ High Blood Pressure	☐ Glaucoma ☐ Cancer:_____ ☐ Diabetes	☐ Osteoporosis ☐ Other: _____
Sibling Gender: **F / M**	Y / N	____	☐ Depression ☐ Genetic Disease ☐ Heart Attack	☐ Stroke ☐ Autoimmune Disease ☐ High Blood Pressure	☐ Glaucoma ☐ Cancer:_____ ☐ Diabetes	☐ Osteoporosis ☐ Other: _____
Sibling Gender: **F / M**	Y / N	____	☐ Depression ☐ Genetic Disease ☐ Heart Attack	☐ Stroke ☐ Autoimmune Disease ☐ High Blood Pressure	☐ Glaucoma ☐ Cancer:_____ ☐ Diabetes	☐ Osteoporosis ☐ Other: _____
Child Gender: **F / M**	Y / N	____	☐ Depression ☐ Genetic Disease ☐ Heart Attack	☐ Stroke ☐ Autoimmune Disease ☐ High Blood Pressure	☐ Glaucoma ☐ Cancer:_____ ☐ Diabetes	☐ Osteoporosis ☐ Other: _____
Child Gender: **F / M**	Y / N	____	☐ Depression ☐ Genetic Disease ☐ Heart Attack	☐ Stroke ☐ Autoimmune Disease ☐ High Blood Pressure	☐ Glaucoma ☐ Cancer:_____ ☐ Diabetes	☐ Osteoporosis ☐ Other: _____
_____	Y / N	____	☐ Depression ☐ Genetic Disease ☐ Heart Attack	☐ Stroke ☐ Autoimmune Disease ☐ High Blood Pressure	☐ Glaucoma ☐ Cancer:_____ ☐ Diabetes	☐ Osteoporosis ☐ Other: _____

Other Family History (*grandparents, extended family*):

OTHER MEDICAL PROVIDERS	*Specialty / Practice Name*
①	
②	
③	

DURABLE MEDICAL EQUIPMENT	*Supplies*
①	
②	

REVIEW OF SYSTEMS (*Please Check All Symptoms That Have Concerned You In the Last Month*)

CONSTITUTIONAL

- ☐ Fever
- ☐ Fatigue
- ☐ Night Sweats / Chills
- ☐ Decreased Appetite

EYES

- ☐ Vision Change
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Cataracts

EARS, NOSE, THROAT

- ☐ Ear Pain
- ☐ Ringing in Ears
- ☐ Hearing Loss
- ☐ Runny Nose
- ☐ Sinus Pressure
- ☐ Frequent Nosebleeds
- ☐ Dry Mouth
- ☐ Mouth Ulcers
- ☐ Bleeding Gums
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Difficulty Swallowing

NEUROLOGICAL

- ☐ Dizziness / Dizzy Spells
- ☐ Numbness / Tingling
- ☐ Headaches
- ☐ Vertigo
- ☐ Tremors
- ☐ Fainting
- ☐ Seizure
- ☐ Weakness

HEMATOLOGIC / LYMPHATIC

- ☐ Swollen Glands
- ☐ Easy Bleeding / Bruising

RESPIRATORY

- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Wheezing

SKIN

- ☐ Rash
- ☐ Persistent Itch
- ☐ Growth / Lesion
- ☐ Change in Mole(s)
- ☐ Skin Yellowing

CARDIOVASCULAR

- ☐ Chest Pain / Pressure
- ☐ High Blood Pressure
- ☐ Irregular Heartbeats
- ☐ Swelling / Edema
- ☐ Shortness of Breath with Lying Down
- ☐ Shortness of Breath with Exertion
- ☐ Awakening Short of Breath

GENITOURINARY

- ☐ Urine Retention
- ☐ Painful Urination
- ☐ Urinary Frequency
- ☐ Abnormal Vaginal Bleeding
- ☐ Urinary Loss of Control

GASTROINTESTINAL

- ☐ Abdominal Pain
- ☐ Nausea / Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Indigestion / Heartburn
- ☐ Black / Bloody Stool

MUSCULOSKELETAL

- ☐ Joint Pain
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness

ENDOCRINE

- ☐ Excessive Thirst
- ☐ Intolerance to Heat / Cold

ALLERGIC / IMMUNOLOGIC

- ☐ Hay Fever

PSYCHOLOGICAL

- ☐ Depression
- ☐ Anxiety
- ☐ Mania
- ☐ Difficulty Sleeping

IMMUNIZATIONS	*Date*	*Date*	*Date*	*Date*
Flu Shot (Influenza)				
Hepatitis A	1st	2nd		
Hepatitis B	1st	2nd	3rd	
HPV / Gardasil	1st	2nd	3rd	
Meningococcal				
MMR (Measles, Mumps, Rubella)				
Pneumonia (Pneumovax) / Prevnar-13				
Shingles (Zostavax)				
T-DAP (Tetanus, Pertussis)				
Tetanus				

HEALTH MAINTENANCE			
Test	***Date***	***Result***	***Location / Provider***
Physical/Medicare Wellness Visit			
Colonoscopy / Colorectal Screen			
Mammogram			
Eye Exam / Vision			
Hearing Test			
Dental Exam			
Bone Density			
Prostate Exam			
PSA Blood Test			

OTHER HEALTH HISTORY
Have you completed an Advance Directive? ☐ Yes (Date(s): _____) ☐ No
Do you know what an Advance Directive is? ☐ Yes ☐ No
Other Information:_____ _____ _____ _____ _____ _____ _____ _____

I certify that all the information is correct to the best of my knowledge. I will not hold my doctor or any staff members responsible for any errors or omissions I may have made in the completion of this form.

Patient Signature: _____ **Date:** _____