Today's Date: _____

Revised: _____

_____

GOLDEN TRIANGLE FAMILY CARE CENTER

Health History Questionnaire

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

Name: _____ ❑ M ☐ F Age: _____ ___

Previous doctor: _____ Date of last physical exam: _____

CHIEF COMPLAINT

What brought you here today? _____

_____

When did it begin? _____

What makes it better? _____ What makes it worse? _____

PERSONAL HEALTH HISTORY

Childhood Illnesses: ☐Measles ☐ Mumps ☐Rubella ☐ Chickenpox ☐Rheumatic Fever ☐Polio

Immunizations with dates: (if patient is under 18 years of age, please provide copy of shot record)					
Tetanus/Td		Influenza (flu)		Hepatitis A	
Meningitis		Pneumonia		Hepatitis B	

Allergies to medications

Name the drug	Reaction	Name the drug	Reaction
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Hospitalizations and Surgeries Have you ever had a blood transfusion? ☐ Y ☐ N

Year	Illness or Operation	Doctor/Hospital

Medications

(Please list all prescribed drugs, over the counter drugs, vitamins, & supplements)

Medication and Strength	Frequency	Medication and Strength	Frequency
1.		11.	
2.		12.	
3.		13.	
4.		14.	
5.		15.	
6.		16.	
7.		17.	
8.		18.	
9.		19.	
10.		20.	

Health Habits

Do you drink alcohol? ❑ Y ❑ N

If yes, what kind and how often? _____ How many years? _____

Do you use tobacco? ❑ Y ❑ N ❑ Cigarettes ❑ Cigars ❑ Pipe ❑ Chew/dip

_____#/day? _____of years Year quit: _____

Do you use street drugs? ❑ Y ❑ N If yes, what? _____

Personal Safety

Do you live alone? ❑ Y ❑ N Do you have frequent falls? ❑ Y ❑ N

Do you have vision loss? ❑ Y ❑ N Do you have hearing loss? ❑ Y ❑ N

Do you have an Advanced Directive or Living Will? ❑ Y ❑ N

Would you like information on the preparation of these? ❑ Y ❑ N

Do you have a pacemaker?	Is there metal in your body?	Are you claustrophobic?

FAMILY HEALTH HISTORY

Father Living? ❑ Y ❑ N If no, cause of death? _____.

Mother Living? ❑ Y ❑ N If no, cause of death? _____.

Siblings Brothers? How many? _____. Sisters? How many? _____.

(Please place appropriate letter in the box that applies to that relative.)

F = Father M = Mother B = Brother S= Sister

Cancer	High Blood Pressure	Anemia
Diabetes	Heart Attack	Bleeding Disorders
Asthma	Heart Disease	High Cholesterol
Tuberculosis	Stroke	Osteoporosis
Seizures	Kidney Disease	Arthritis
Depression	Liver Disease	Migraine
Anxiety	Glaucoma	Lupus
Mental Illness	Thyroid Problems	Rheumatoid Arthritis

YOUR MEDICAL HISTORY

Please check if YOU have had or been diagnosed with any of the following:

- ☐ Diabetes
- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Cancer of the_____
- ☐ Depression
- ☐ Anxiety
- ☐ Mental Illness _____
- ☐ Bipolar Disorder
- ☐ Anemia
- ☐ Thyroid Problems
- ☐ Epilepsy/Seizures
- ☐ Migraine Headaches
- ☐ Kidney Stones/Kidney Disease
- ☐ Congestive Heart Failure
- ☐ Heart Attack - Date:_____
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Stroke
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Bleeding Problems
- ☐ Blood Disorders _____
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Crohn's disease
- ☐ Glaucoma
- ☐ Other_____

Review of symptoms: (please check if you have or have ever had the following)

GENERAL:

- ☐ Recent weight loss
- ☐ Recent weight gain
- ☐ Weakness
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Recent loss of appetite

HEAD:

- ☐ Double/blurred vision
- ☐ Eye pain
- ☐ Cataracts
- ☐ Headaches
- ☐ Ringing in ears
- ☐ Dizziness
- ☐ Fainting spells
- ☐ Decreased hearing
- ☐ Ear drainage
- ☐ Frequent ear infections
- ☐ Nosebleeds
- ☐ Hayfever/Allergies
- ☐ Frequent sore throats
- ☐ Prolonged hoarseness
- ☐ Swelling in neck area

RESPIRATORY:

- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Pain with breathing
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Night Sweats
- ☐ Exposure to Tuberculosis?

CARDIOVASCULAR:

- ☐ Chest pain
- ☐ Irregular heartbeat/pulse
- ☐ Shortness of breath with activity
- ☐ Legs/ankles swelling
- ☐ Unable to sleep lying flat
- ☐ Wake up short of breath
- ☐ Varicose veins
- ☐ Bruise easily

GASTROINTESTINAL:

- ☐ Difficulty swallowing
- ☐ Frequent heartburn
- ☐ Nausea/Vomiting
- ☐ Vomiting blood
- ☐ Vomiting w/ appearance of coffee grounds
- ☐ Gallbladder problems
- ☐ Abdominal pain
- ☐ Bloating/discomfort
- ☐ Diarrhea
- ☐ Constipation
- ☐ Irritable bowels
- ☐ Jaundice
- ☐ Dark/tarry stools
- ☐ Change in size of stool
- ☐ Blood in stool
- ☐ Rectal pain
- ☐ Rectal bleeding
- ☐ Hemorrhoids
- ☐ Hernia

GENITOURINARY:

- ☐ Burning/pain with urination
- ☐ Frequent urination
- ☐ Urgency to urinate
- ☐ Leaking urine
- ☐ Decrease in force/flow of urine
- ☐ Blood in urine
- ☐ Frequent urinary infection
- ☐ Kidney stones
- ☐ Bedwetting
- ☐ Sexually Transmitted Disease
- ☐ Sexual problems

NEUROMUSCULAR:

- ☐ Convulsions / Seizures
- ☐ Paralysis
- ☐ Tremors
- ☐ Numbness to hands or feet
- ☐ Loss of coordination
- ☐ Memory loss
- ☐ Muscle twitching
- ☐ Muscle aches
- ☐ Back pain
- ☐ Joint injury
- ☐ Foot pain
- ☐ Osteoporosis
- ☐ Gout

SKIN:

- ☐ Psoriasis
- ☐ Eczema
- ☐ Hives
- ☐ Rashes
- ☐ Cracking skin
- ☐ Deformed toenails/fingernails
- ☐ Unexplained hair loss
- ☐ Boils / Abscesses

MENTAL HEALTH:

- ☐ Concentration problems
- ☐ Depression
- ☐ Nervousness
- ☐ Agitation
- ☐ Anger issues
- ☐ Insomnia
- ☐ Phobias
- ☐ Suicidal thoughts

WOMEN ONLY

1. Do you menstruate? ☐ Y ☐ N
2. If no, please explain _____
3. Are you regular? ☐ Y ☐ N
4. Period every _____ days.
5. What age did you start menstruating? _____
6. Date of last menstrual cycle: _____
7. Number of pregnancies: _____
8. Number of miscarriages: _____
9. Number of abortions: _____
10. Number of live births: _____
11. Are you pregnant now? ☐ Y ☐ N
12. Are you breastfeeding? ☐ Y ☐ N
13. Date of last mammogram: _____
14. Date of last pap smear: _____
15. Breast tenderness? ☐ Y ☐ N
16. Breast lumps/masses? ☐ Y ☐ N
17. Nipple discharge? ☐ Y ☐ N