HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First, M.I.):* ☐ M ☐ F		**DOB:**
Previous or referring doctor:	**Date of last physical exam:**	
Job Title:		
Pharmacy Name:	**Pharmacy Phone Number:**	

PERSONAL HEALTH HISTORY			
Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio			
Immunizations and dates:	☐ Tetanus	☐ Pneumonia	
	☐ Hepatitis	☐ Chickenpox	
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*	
Screenings	**Date**		
☐ Colonoscopy			
☐ TIT/Stool Test			
☐ Mammogram			
☐ Pap Smear			

Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

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

Patient Name:	**Date of Birth:**

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers, herbal supplements		
Name the Drug	Strength/Amount	Frequency Taken
Allergies to medications/seasonal/environment or N/A		
Name the allergen	Reaction You Had	

LIFESTYLE AND RESIDENCE INFORMATION			
Support:	Support Person #1:		
	Support Person #2:		
	Support Person #3:		
Religion:			
Have you Traveled outside the area?	☐ Yes ☐ No	If yes, where?	
Education (highest grade completed):			
Housing status:	☐ Not Homeless ☐ Doubling Up ☐ Shelter ☐ Street ☐ Transitional		
Do you have?	☐ Smoke detectors ☐ Firearms in the home		
Have you ever been a victim of abuse or domestic violence?	**☐ YES ☐ NO**		
Do you feel safe at home?	**☐ YES ☐ NO**	**Do you live alone?**	**☐ YES ☐ NO**

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	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol? ☐ Rarely ☐ Occasionally ☐ Socially				☐ 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
Tobacco	Do you use tobacco? ☐ Rarely ☐ Occasionally ☐ Socially				☐ 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
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 or barrier 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
	May we have a copy if yes?				☐ Yes	☐ No

Patient Name:	**Date of Birth:**

	Physical and/or mental abuse have 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

VISION QUESTIONNAIRE

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Are you currently wearing contacts?	☐ **YES** ☐ **NO**
Do you currently have prescription glasses?	☐ YES ☐ NO
Please list any eye disorders you have been diagnosed with	

RELEVANT FAMILY HEALTH HISTORY

☐ **NO RELEVANT FAMILY HISTORY** ☐ **ADOPTED**

	MOTHER	FATHER	BROTHER	SISTER	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANMOTHER	PATERNAL GRANDFATHER	AUNTS/ UNCLES
CANCER									
DIABETES									
HIGH BLOOD PRESSURE									
HEART ATTACK									
HEART DISEASE									
BLOOD CLOTS/ DVT									
STROKE									
MENTAL ILLNESS									
DRUG/ALCOHOL ADDICTION									
Glaucoma or macular degeneration									
OTHER DISEASES NOT MENTIONED									
LIVING?									

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

Patient Name:	**Date of Birth:**

DENTAL PROBLEMS					
☐	Bad breath	☐	Food collection between teeth	☐	Orthodontic treatment
☐	Bleeding gums	☐	Foreign objects	☐	Pain around ear
☐	Blisters on lips/mouth	☐	Grinding teeth	☐	Periodontal treatment
☐	Bubble or pimple on gum	☐	Gums swollen or tender	☐	Sensitivity to cold
☐	Burning sensation on tongue	☐	Jaw pain or tiredness	☐	Sensitivity to heat
☐	Chew on one side of mouth	☐	Lip or cheek biting	☐	Sensitivity to sweets
☐	Clicking or popping jaw	☐	Loose teeth or broken fillings	☐	Sensitivity when biting
☐	Dry mouth	☐	Mouth breathing	☐	Sores or growths in your mouth
☐	Fingernail biting	☐	Mouth pain, brushing	☐	

OTHER MEDICALLY DIAGNOSED PROBLEMS							
☐	Abdominal Discomfort	☐	Colitis	☐	High blood pressure	☐	Radiation treatment
☐	Acid Reflux	☐	Congenital heart lesions	☐	Indigestion	☐	Recent Surgery
☐	ADD	☐	Cortisone treatments	☐	Irritable Bowel Syndrome	☐	Respiratory disease
☐	ADHD	☐	Cough, persistent/bloody	☐	Jaundice	☐	Rheumatic fever
☐	AIDS/HIV	☐	Cystic Fibrosis	☐	Joint Replacement	☐	Scarlet Fever
☐	Alcohol Abuse	☐	Dental Visit Anxiety	☐	Kidney disease	☐	Shortness of breath
☐	Anemia	☐	Depression	☐	Kidney stones	☐	Sinus trouble
☐	Anxiety	☐	Diabetes	☐	Light-headedness	☐	Skin rash/disorders
☐	Arthritis/Rheumatism	☐	Down Syndrome	☐	Liver disease	☐	Special diet
☐	Artificial heart valves	☐	Ear Pain	☐	Low blood pressure	☐	Stroke
☐	Artificial joints	☐	Emphysema	☐	Mitral valve prolapsed	☐	Swollen feet or ankles
☐	Asthma	☐	Epilepsy	☐	Muscular Dystrophy	☐	Swollen neck glands
☐	Autism	☐	Fainting or dizziness	☐	Neck Pain	☐	Thyroid problems
☐	Back problems	☐	Glaucoma	☐	Nausea	☐	Tonsillitis
☐	Bleeding abnormally	☐	Hay fever	☐	Nervous problems	☐	Tuberculosis
☐	Blood disease	☐	Head/Neck radiation	☐	Osteoporosis	☐	Tumor or growths
☐	Bronchitis	☐	Headaches	☐	Pacemaker	☐	Ulcer
☐	Cancer	☐	Heart murmur	☐	Palpitations	☐	Venereal Disease
☐	Chemical dependency	☐	Heart problems	☐	Persistent Cough	☐	Weight loss or gain
☐	Chemotherapy	☐	Hepatitis	☐	Pneumonia		
☐	Circulatory problems	☐	Herpes	☐	Psychiatric care		

Do You Need to pre-medicate for dental procedures?	☐ Yes	☐ No
Are you taking blood thinners?	☐ Yes	☐ No

Do you have any physical limitations? (Wheelchair, walker, mobility)	☐ Yes	☐ No

- If Yes, please describe:

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