Carondelet Medical Group. Be well.

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. For additional information write or attach on back.

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**		**Date:**

PERSONAL HEALTH HISTORY

Medication - List your prescriptions include OTC drugs, such as vitamins and inhalers. ☐ **No medications taken**

Name the Drug	Strength	Frequency	Name the Drug	Strength	Frequency

Allergies- Include antibiotics, narcotics, anesthetics, Iodine, IV, dye, latex, insect bites, stings, food ☐ **No known allergies**

Name	Reaction	Name	Reaction

Medical History- I have had the following medical conditions: (check all that apply, write in others) ☐ **No health problems**

Cardiovascular Disease	☐ High Blood Pressure ☐ High Cholesterol ☐ Angina ☐ Heart Attack ☐ Congestive Heart Failure ☐ Heart Valve problem ☐ Rheumatic Heart Disease ☐ Stroke ☐ TIA ☐ Varicose Veins
Endocrine Problems	☐ Diabetes ☐ Thyroid Disorder ☐ Adrenal Gland Disease
Lung Disease	☐ Asthma ☐ COPD ☐ Emphysema ☐ Pneumonia ☐ Sleep Apnea ☐ Tuberculosis ☐ Valley Fever
Musculoskeletal	☐ Arthritis ☐ Chronic Back Pain ☐ Fractures/dislocations ☐ Osteoporosis
Gastrointestinal	☐ Diverticular disease ☐ Esophageal reflux(GERD) ☐ Hepatitis A/B/C ☐ Hemorrhoids ☐ Inflammatory Bowel Disease ☐ Liver problem ☐ Pancreas problem ☐ Ulcer
Kidney disease	☐ Kidney Stones ☐ Renal Failure ☐ Recurrent Urinary Tract Infections
Blood Disorder	☐ Anemia ☐ Blood clots ☐ Blood Transfusion ☐ HIV Positive ☐ AIDS
Infections	☐ Sexually Transmitted Infection ☐ MRSA
Neurologic Diseases	☐ Migraine Headache ☐ Peripheral Neuropathy ☐ Seizures / Epilepsy
Eye Problems	☐ Diabetic Eye disease ☐ Cataracts ☐ Glaucoma
Psychiatric Disorder	☐ Depression ☐ Anxiety ☐ Bipolar Disorder ☐ Eating Disorder
Cancer	List Type:

Specialists you currently see		
Recent Hospitalization in the last year	**Date:**	**Location:**
How many times pregnant?		**# Children**

Surgeries/Procedures ☐ **No Surgeries/Procedures**

☐ Appendectomy (Appendix)	Hysterectomy ☐ Partial ☐ Total	☐ Coronary Stent	☐ Vasectomy	☐ Knee Procedure
☐ Tonsillectomy	☐ Cesarean Section	☐ Coronary Bypass	☐ Prostate Procedure	☐ Hip Procedure
☐ Gall Bladder (Cholecystectomy)	☐ Tubal Ligation	☐ Heart Valve Surgery	☐ Colon Procedure	☐ Back Procedure
☐ Hernia Repair	☐ Breast Procedure/Surgery	☐ Cardiac Pacemaker	☐ Eye Procedure	☐ Sinus Procedure
☐ Other Surgeries:				

Doctor/Clinician Signature: _____Date:_____

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Name (Last, First, M.I.):		DOB:	Date:

SOCIAL HISTORY AND HABITS

Tobacco	**Smoking Status:** ☐ Never smoker ☐ Former Smoker ☐ Current every day smoker ☐ Current some day smoker ☐ Heavy tobacco smoker ☐ Light tobacco smoker ☐ Unknown tobacco status	**Tobacco Type:** ☐ Cigarettes ☐ Cigars ☐ Oral ☐ Pipe ☐ Other:	**Describe your daily tobacco use**: _____ # Packs _____ # Cigarettes _____ # Chew/day	Previous Quit Attempts: ☐ None ☐ Counseling ☐ Hypnosis ☐ Medications ☐ Nicotine replacement
	_____ Number of Years	_____ Age Started	_____ Age Quit	

Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Other:	Amount per day?
Alcohol	Do you drink alcohol? ☐ Yes ☐ No			If yes, what type/amount per week?	
Exercise	Type:			Frequency:	
Hobbies	List hobbies, activities and sports:				
Drugs	Do you use recreational drugs? ☐ Yes ☐ No		Type:		Amount:
Sexuality	☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transgender				
Marital status	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				
Employment/School	Occupation?		Place of employment/school?		
Personal/Safety	Who do you live with?				
	Do you typically wear a seat belt? ☐ Yes ☐ No				
	Do you have a medical power of attorney? ☐ Yes ☐ No		Do you have a Living Will? ☐ Yes ☐ No		
	Do you feel threatened physically, sexual, verbally in your domestic relationship? ☐ Yes ☐ No				

FUNCTIONAL ASSESSMENT

Self-Care ability

	Independent	Require Assistance	Decline in ability
Ambulation	☐	☐	☐
Chewing skills	☐	☐	☐
Stair Climbing	☐	☐	☐
Bed Mobility	☐	☐	☐
Drinking Skills	☐	☐	☐
Transferring	☐	☐	☐
Hygiene/Bathing	☐	☐	☐
Toileting	☐	☐	☐
Dressing	☐	☐	☐
Eating Skills	☐	☐	☐
Swallowing	☐	☐	☐
Speaking	☐	☐	☐
Cognition	☐	☐	☐

Sensory Deficits

☐ None ☐ Blind, left eye ☐ Blind, right eye ☐ Cognitive deficit ☐ Hearing deficit, left
☐ Hearing deficit, right ☐ Sensation/touch deficit ☐ Uncorrected visual impairment
☐ Other:

Medical Equipment

List Type (assistive devices, wheelchair, dentures, hearing aids, shower chairs, etc...):

Doctor/Clinician Signature: _____Date:_____

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Name (Last, First, M.I.):		DOB:	Date:

REVIEW OF SYMPTOMS

Please check any of the following you have had within the last 3 months.

GENERAL	GASTROINTESTINAL	NEUROLOGICAL
☐ Unintended weight gain	☐ Difficulty swallowing	☐ Arm/leg numbness/weakness/tingling
☐ Unintended weight loss	☐ Abdominal pain	☐ Balance problem/dizziness/vertigo
☐ Always tired/fatigue	☐ Nausea	☐ Fainting
☐ Appetite change	☐ Heartburn/Ulcer	☐ Significant headache
☐ Unexplained fever/sweats	☐ Vomiting/Vomiting blood	☐ Head injury
☐ Frequent sleep problem	☐ Diarrhea	☐ Memory loss/Confusion
☐ Chills	☐ Constipation	☐ Paralysis
EYES/EARS/NOSE/THROAT	☐ Bloody or black stools	☐ Seizures/Convulsions
☐ Visual change	☐ Special diet	☐ Tremors
☐ Difficulty Hearing	☐ Jaundice/liver problem	☐ Stroke
☐ Earaches	☐ Indigestion/reflux	**MUSCULOSKELETAL**
☐ Frequent nosebleeds	☐ Lack of appetite	☐ Back Pain
☐ Sneezing	**GENITOURINARY/GYN**	☐ Difficulty walking/Falls
☐ Sore/bleeding gums	☐ Blood in urine	☐ Joint swelling/Joint Pain
☐ Dental problems	☐ Frequent urination	☐ Leg Swelling
☐ Sore Throat	☐ Painful urination	☐ Varicose Veins
☐ Hoarse	☐ Bladder infection	☐ Leg ulcers/sores
☐ Swollen Glands	☐ Kidney failure	☐ Neck pain
☐ Wear Glasses/contacts	☐ Prostate Enlargement	☐ Leg cramping/discomfort
☐ Sinus infection	☐ Sexually Transmitted Infection	☐ Foot pain at night
☐ Dizziness	☐ Penis sore/discharge	☐ Weakness
RESPIRATORY	☐ Testicle pain/lump	☐ Extremity pain
☐ Pain with breathing	☐ Sexual difficulty	**SKIN**
☐ Shortness of breath	☐ Urinary loss of control/leaking	☐ Abnormal bleeding/bruising
☐ Wheezing	☐ Irregular periods	☐ Mole color/size change
☐ Sleeping “propped up”	☐ Heavy or painful periods	☐ Change in hair/nails
☐ Home Oxygen	☐ Vaginal itching/discharge	☐ Rash/itching/dry
☐ Cough	☐ Post-menopausal	☐ Skin Ulcer
CARDIOVASCULAR	☐ Hormones after menopause	☐ Acne
☐ Chest pain	☐ Breast lump	☐ Profuse sweating
☐ Chest pain with activity	☐ Nipple discharge	**PSYCHIATRIC**
☐ Palpitations/irregular pulse	**ENDOCRINE**	☐ Anxiety
☐ Leg pain when walking	☐ Excessive thirst	☐ Bothered by feeling down, depressed, or hopeless during the past month
☐ Swelling in legs or arms	☐ Heat/cold intolerance	☐ Bothered by little interest or pleasure in doing things during the past month
☐ Vein problems	☐ Changes in voice/hat/glove size	☐ Suicidal tendencies
☐ Racing heart	☐ Steroid use	☐ Victim of abuse physically or sexual
☐ Blackouts/passing out	☐ Hyperthyroidism	☐ Panic attacks
	☐ Hypothyroidism	
	☐ Hot flashes	

☐ Other symptoms not listed above:

Doctor/Clinician Signature: _____Date:_____

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FAMILY HEALTH HISTORY

Do you have a parent, sibling, child with the following? Please select the family member. ☐ **Unknown** ☐ **Adopted**

	Father	Mother	Other-How related?		Father	Mother	Other-How related?
☐ Cancer :Ovarian/Uterine	☐	☐	☐	☐ Osteoporosis	☐	☐	☐
☐ Cancer: Breast	☐	☐	☐	☐ High Blood Pressure	☐	☐	☐
☐ Cancer: Prostate Cancer	☐	☐	☐	☐ Mental illness	☐	☐	☐
☐ Cancer: Colon	☐	☐	☐	☐ Thyroid Disease	☐	☐	☐
☐ Cancer Other Type?	☐	☐	☐	☐ Stroke	☐	☐	☐
☐ Diabetes	☐	☐	☐	☐ Glaucoma	☐	☐	☐
☐ Heart Disease	☐	☐	☐	☐ Other :	☐	☐	☐

HEALTH MAINTENANCE

Women's Health Screening Tests (Most Recent Date)

PAP/Pelvic exam	Date:	☐ Normal ☐ Abnormal-If abnormal PAP smear, what treatment was received?
Mammogram	Date:	☐ Normal ☐ Abnormal
Bone Density(DEXA)	Date:	☐ Normal ☐ Abnormal

Screening Tests (Most Recent Date)

Colonoscopy	Date:	☐ Normal ☐ Abnormal	Stool Blood Test	Date:	☐ Normal ☐ Abnormal
Eye Exam	Date:	☐ Normal ☐ Abnormal	Prostate/Rectal	Date:	☐ Normal ☐ Abnormal

IMMUNIZATIONS

Influenza	☐ Yes ☐ No	Date:	Pneumonia	☐ Yes ☐ No	Date:	Tetanus	☐ Yes ☐ No	Date:
Hepatitis B Series	☐ Yes ☐ No	Date:	Shingles	☐ Yes ☐ No	Date:	Tetanus w/ Pertussis	☐ Yes ☐ No	Date:
Hepatitis A Series	☐ Yes ☐ No	Date:	HPV (human papilloma virus)	☐ Yes ☐ No	Date:	MMR	☐ Yes ☐ No	Date:

PREFERRED PHARMACY

At which pharmacy do you prefer to pick up prescriptions?

Pharmacy Name:	
Address (or cross-streets if address not known)	
City/State:	

Doctor/Clinician Signature: _____Date:_____