HEALTH HISTORY QUESTIONNAIRE

MedPeds Associates of Sarasota, PA

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

Today's Date: _____ ☐ Adult (over 18 years) ☐ Minor (0-17 years)

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	
Pharmacy name:	**Pharmacy location:**
What is your main concern for today's visit?	
What other topics would you like to discuss today?	

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox/Shingles
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

Previous diagnostic testing and dates:	☐ Colonoscopy	☐ Stress test
	☐ DEXA bone scan	☐ Echocardiogram
	☐ Mammogram	☐ Carotid ultrasound
	☐ Pap smear	☐ Lower extremity ultrasound
	☐ PSA	☐ Cholesterol level
	☐ Chest xray	☐ Routine blood test
	☐ Pulmonary function test	☐ Eye exam
	☐ Electrocardiogram	☐ Hearing test

General Medical History ☐ No medical history

	Medical Problem	Year		Medical Problem	Year		Medical Problem	Year		Medical Problem	Year
☐	Heart disease		☐	Crohn's disease		☐	Blood clots		☐	Shingles	
☐	Heart valve disease		☐	Colon polyps		☐	Cancer		☐	Kidney disease	
☐	Heart attack		☐	Diverticulitis		☐	Chronic back pain		☐	Anorexia	
☐	Heart stent placement		☐	Gall stones		☐	Fractures		☐	Anxiety	
☐	High blood pressure		☐	Hemorrhoids		☐	Arthritis – degenerative		☐	Bipolar disorder	
☐	High cholesterol		☐	Hepatitis A		☐	Arthritis – rheumatoid		☐	Bulimia	
☐	High triglycerides		☐	Hepatitis B		☐	Lupus		☐	Depression	
☐	Varicose veins		☐	Hepatitis C		☐	Osteoporosis		☐	Epilepsy	
☐	Asthma		☐	Irritable bowel disease		☐	Osteopenia		☐	Schizophrenia	
☐	COPD		☐	Liver disease		☐	Type 1 diabetes		☐	Tonsillectomy	
☐	Respiratory disease		☐	Rectal bleeding		☐	Type 2 diabetes		☐	Appendectomy	
☐	Allergies		☐	Ulcerative colitis		☐	Hyperthyroidism		☐	Gall bladder removal	
☐	Bronchitis		☐	Anemia		☐	Migraine headaches				
☐	Sinusitis		☐	Bleeding disorder		☐	Stroke/CVA				

Surgeries ☐ **No surgical history**		
Year	Reason	Hospital

Other hospitalizations ☐ **No hospitalizations**		
Year	Reason	Hospital

Specialists and physicians seen in the past 10 years ☐ **No specialists or other physicians**			
Specialist name	Reason	Current?	Location (City and State)
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	

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

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers ☐ **No medications**		
Name of the Drug	Strength	Frequency Taken

Allergies to medications ☐ **No known medication allergies**	
Name of the Drug	Reaction You Had

SOCIAL HISTORY

What type of work do you do?		
Do you have any children?	☐ Yes ☐ No	How many children do you have?
Do you have any pets?	☐ Yes ☐ No	What kind of pets do you have?
Do you travel out of the country?	☐ Yes ☐ No	Where have you traveled?
Have you had travel vaccines?	☐ Yes ☐ No	

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	☐ Medium	☐ Low		
	Rank fat intake	☐ High	☐ Medium	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Soda		
	# 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 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
Personal Safety	Do you wear your seatbelt?				☐ Yes	☐ No
	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 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

FAMILY HEALTH HISTORY

Alcoholism	☐ Yes ☐ No	Heart disease	☐ Yes ☐ No
Thyroid disorder	☐ Yes ☐ No	Heart attack <50 years old	☐ Yes ☐ No
Breast cancer	☐ Yes ☐ No	Heart attack >50 years old	☐ Yes ☐ No
Colon cancer	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Elevated cholesterol	☐ Yes ☐ No
Other:			