

WMA HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Patient Name: _____ Patient DOB: _____

How would you rate your general health? Excellent Good Fair Poor

Main reason for today's visit: _____

Other concerns: _____

PAST MEDICAL HISTORY

Please check all that apply:

HEENT

- Allergies
- Blindness
- Cataracts
- Chronic Sinus Problems
- Glaucoma
- Hearing Loss
- Macular Degeneration
- Other: _____

Cardiovascular

- Atrial Fibrillation
- Circulatory Problems;
Please specify: _____
- Congestive Heart Failure
- Heart Disease; specify: _____
- Heart Attack; when: _____
- Heart Murmur
- High Blood Pressure/Hypertension
- High Cholesterol/Hyperlipidemia
- Valvular Heart Disease
- Other: _____

Genitourinary

- BPH
- Kidney Disease
- Kidney Stones
- Frequent Urinary Tract Infections
- Urinary Incontinence
- Other: _____

Psychiatric

- Alcohol Problems
- Anxiety
- Depression
- Drug Problems/Addiction
- Other: _____

Respiratory

- Asthma
- Bronchitis
- COPD
- Emphysema
- Pneumonia
- Tuberculosis
- Other: _____

Gastrointestinal

- Celiac Disease
- Crohn's Disease
- Eating Disorder (Anorexia/Bulimia)
- Gastritis (Stomach Pain)
- Hemorrhoids
- Hepatitis
- Hernias
- Irritable Bowel Syndrome
- Jaundice
- Pancreatitis
- Ulcerative Colitis
- Reflux (Frequent Indigestion)
- Ulcers
- Other: _____

Endocrine

- Diabetes Mellitus Type I; age of onset: _____
- Diabetes Mellitus Type II; age of onset: _____
- Gestational Diabetes
- Hyperthyroidism
- Hypothyroidism
- Other: _____

Musculoskeletal

- Arthritis
- Osteoporosis/Osteopenia
- Scoliosis
- Other: _____

Neurologic

- Epilepsy
- Head Injury/Concussions
- Headaches
- Migraines
- Seizures
- Stroke
- Other: _____

Hematology/Cancer

- Anemia
- Blood Clots
- Breast Cancer
- Colon Cancer
- Prostate Cancer
- Cancer; Other: _____

Skin Disorders

- Eczema
- Psoriasis
- Skin Cancer
- Other: _____

Rheumatologic

- Fibromyalgia
- Gout
- Lupus
- Osteoarthritis
- Rheumatoid Arthritis
- Other: _____

STD's

- Chlamydia
- Genital Herpes
- Genital Warts
- Gonorrhea
- HIV/AIDS
- Other: _____

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic

- Frequent Sneezing
- Hives
- Itching
- Runny Nose
- Sinus Pressure

Cardiovascular

- Arm Pain on Exertion
- Chest Pain on Exertion
- Chest Heaviness/Pressure on Exertion
- Irregular Heart Beats (Palpitations)
- Known Heart Murmur
- Light-headed on Standing
- Shortness of Breath When Lying Down
- Shortness of Breath When Walking
- Swelling (edema)

Constitutional

- Exercise Intolerance
- Fatigue
- Fever
- Weight Gain (____lbs)
- Weight Loss (____lbs)

Eyes

- Dry Eyes
- Irritation
- Vision Change
- Date of Last Exam: _____

Ears/Nose/Mouth/Throat

- Bleeding Gums
- Difficulty Hearing
- Dizziness
- Dry Mouth
- Ear Pain
- Frequent Infections
- Frequent Nosebleeds
- Hoarseness
- Mouth Breathing
- Mouth Ulcers
- Nose/Sinus Problems
- Ringing in Ears

Endocrine

- Fatigue
- Increased Thirst/Hunger/Urination

Gastrointestinal

- Abdominal Pain
- Black or Tarry Stool
- Blood in Stool
- Change in Appetite
- Frequent Indigestion
- Hemorrhoids
- Trouble Swallowing
- Vomiting
- Vomiting Blood

Genitourinary

- Blood in Urine
- Difficulty Urinating
- Incomplete Emptying
- Increased Urinary Frequency
- Urinary Loss of Control

Hematologic/Lymphatic

- Easy Bruising/Bleeding
- Swollen Glands

Integumentary (Skin)

- Changes in Moles
- Dry Skin
- Eczema
- Growth/Lesions
- Itching
- Jaundice (Yellow Skin/Eyes)
- Rash

Musculoskeletal

- Back Pain
- Joint Pain
- Muscle Aches
- Muscle Weakness

Neurological

- Dizziness
- Fainting
- Headaches
- Memory Loss
- Migraines
- Numbness
- Restless Legs
- Seizures
- Weakness

Psychiatric

- Alcohol Overuse
- Anxiety/Stress
- Depression
- Do Not Feel Safe in Relationship
- Mania
- Sleep Problems

Respiratory

- Cough
- Coughing Up Blood
- Shortness of Breath
- Sleep Apnea
- Snoring
- Wheezing

MEN ONLY

- PSA Date: _____ Abnormal
- Pain or lump(s) in testicles
 - Penile (penis) itching, burning or discharge
 - Problems starting or stopping your urine stream
 - Wake in the night to go to the bathroom
 - Sexual problems or concerns
 - History of sexually transmitted disease
 - Sexually active
 - Current sexual partner is Female Male
 - Do you use condoms? Yes No
 - Interested in being screened for STD's
 - Vasectomy

WOMEN ONLY

- Last PAP Smear Date _____ Abnormal
- Last Mammogram Date _____ Abnormal
- Age of first menstrual period: _____
- Date of last menstrual period or age of menopause: _____
- Number of pregnancies: _____ births: _____
- miscarriages: _____ abortions: _____
- Cesarean sections If yes, then number: _____
 - Bleeding between periods
 - Heavy periods
 - Extreme menstrual pain
 - Vaginal itching, burning, or discharge
 - Wake in the night to go to the bathroom
 - Hot flashes
 - Breast lump or nipple discharge
 - Painful intercourse
 - Sexually active
 - Current sexual partner is Female Male
 - Do you use condoms? Yes No
 - Other Birth control method used: _____
 - Interested in being screened for STD's

IMMUNIZATION HISTORY

Immunizations and most recent date:

<input type="checkbox"/> Chickenpox	Date: _____	<input type="checkbox"/> Meningococcus	Date: _____
<input type="checkbox"/> Flu Shot	Date: _____	<input type="checkbox"/> MMR (<i>Measles, Mumps, Rubella</i>)	Date: _____
<input type="checkbox"/> Gardasil/HPV	Date: _____	<input type="checkbox"/> Pneumonia	Date: _____
<input type="checkbox"/> Hepatitis A	Date: _____	<input type="checkbox"/> Tdap (<i>Tetanus and pertussis</i>)	Date: _____
<input type="checkbox"/> Hepatitis B	Date: _____	<input type="checkbox"/> Tetanus	Date: _____
		<input type="checkbox"/> Zostavax (<i>Shingles</i>)	Date: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1. _____	_____
2. _____	_____
3. _____	_____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____
13. _____	_____	_____
14. _____	_____	_____
15. _____	_____	_____

HEALTH MAINTENANCE SCREENING TESTS

TEST	DATE	ABNORMAL?
<input type="checkbox"/> Calcium Screen CT	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Colonoscopy	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Bone Density (Osteoporosis)	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Exercise Stress Test	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Lipid (Cholesterol)	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Pulmonary Function Test	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide
Grandfather (maternal)	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide
Grandmother (paternal)	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide
Grandfather (paternal)	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide
Father	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide
Mother	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide
Brother/Sister	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide
Brother/Sister	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide
Other: _____	Y/N	_____	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide

SOCIAL HISTORY

Occupation _____

Education Less than 8th grade High school 2 year college 4 year college Post graduate

Marital Status Married Single Married Divorced Separated Widowed Domestic partner

Exercise Level None (No exercise)
 Occasional exercise (i.e., climb stairs, walk 3 blocks, golf)
 Moderate exercise (i.e., work or recreation, less than 4x/week for 30 min.)
 High level 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? _____
Salt Intake Hi Med Low
Fat Intake Hi Med Low

Caffeine None Occasional Moderate Heavy
of cups/cans per day? _____

Alcohol Do you drink alcohol? Yes No
If so, how often? Occasionally < 3 times a week > 3 times a week
How many drinks per week? _____
Did you ever drink excessively? Yes No
Are you prone to "binge" drinking? Yes No
Do you drive after drinking? Yes No

Tobacco Do you use tobacco? Yes No
If not currently, did you ever 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
If yes, list: _____

Personal Safety Live alone or with others? Yes No
Guns present in home? Yes No
Does anyone smoke in your home? Yes No
Smoke alarm in home? Yes No
Carbon monoxide alarm in home? Yes No
Seatbelts used routinely? Yes No
Sun screen used routinely? Yes No
Advanced directive or living will? Yes No
Colorado CPR directive? Yes No
Durable medical power of attorney? Yes No

Please add any other information about your health that you would like your provider to know here:

Parent, Guardian, or Caregiver Signature

Date