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.

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 specifiy:_____
- ☐ 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:

☐ Chickenpox	Date:_____	☐ Meningococcus	Date:_____
☐ Flu Shot	Date:_____	☐ MMR (*Measles, Mumps, Rubella)*	Date:_____
☐ Gardasil/HPV	Date:_____	☐ Pneumonia	Date:_____
☐ Hepatitis A	Date:_____	☐ Tdap (*Tetanus and pertussis)*	Date:_____
☐ Hepatitis B	Date:_____	☐ Tetanus	Date:_____
		☐ Zostavax (*Shingles)*	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?
☐ Calcium Screen CT	_____	☐ Yes ☐ No
☐ Colonoscopy	_____	☐ Yes ☐ No
☐ Bone Density (Osteoporosis)	_____	☐ Yes ☐ No
☐ Exercise Stress Test	_____	☐ Yes ☐ No
☐ Lipid (Cholesterol)	_____	☐ Yes ☐ No
☐ Pulmonary Function Test	_____	☐ Yes ☐ No

FAMILY HEALTH HISTORY

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