HEALTH HISTORY QUESTIONNAIRE

TriHealth Physician Partners
Health First

Please complete this entire questionnaire. It will provide your care team with important information about your health.
All answers contained in this questionnaire are strictly confidential and will become part of your medical record.

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

Date:_____ **Marital status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of children:_____ **How many live with you?**_____ **Occupation is/was:**_____

Previous or referring doctor:_____ **Date of last physical exam:** _____

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ None

Immunizations and Dates: ☐ Tetanus_____ ☐ Pneumonia_____ ☐ Hepatitis A_____ ☐ Hepatitis B_____

☐ Chickenpox_____ ☐ Influenza_____ ☐ MMR *Measles, Mumps, Rubella*_____ ☐ Meningococcal_____ ☐ None

Tests/Screenings and Dates: ☐ Eye Exam_____ ☐ Colonoscopy_____ ☐ Dexa Scan_____

Surgeries

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

☐ I have had no surgeries

Other hospitalizations

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

☐ I have never been hospitalized

Have you ever had a blood transfusion? ☐ Y ☐ N

Please list other physicians you have seen in the last 12 months, and for what reason.

_____

_____

_____

_____

_____

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

YOUR MEDICAL HISTORY

Please indicate if **YOU** have a history of the following:

- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anesthetic Complication
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Problems
- ☐ Birth Defects
- ☐ Bladder Problems
- ☐ Bleeding Disease
- ☐ Blood Clots
- ☐ Blood Transfusion(s)
- ☐ Bowel Disease
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Colon Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Growth/Development Disorder
- ☐ Hearing Impairment
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Pain/Angina
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ H IV
- ☐ Hives
- ☐ Kidney Disease
- ☐ Liver Cancer
- ☐ Liver Disease
- ☐ Lung Cancer
- ☐ Lung/Respiratory Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Prostate Cancer
- ☐ Rectal Cancer
- ☐ Reflux/GERD
- ☐ Seizures/Convulsions
- ☐ Severe Allergy
- ☐ Sexually Transmitted Disease
- ☐ Skin Cancer
- ☐ Stroke/CVA of the Brain
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Ulcer
- ☐ Visual Impairment
- ☐ Other Disease, Cancer, or Significant Medical Illness
- ☐ NONE of the Above

List other past medical problems:_____

_____

_____

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Drug _____ Dose/Frequency_____ Drug_____ Dose/Frequency _____

Drug _____ Dose/Frequency_____ Drug_____ Dose/Frequency _____

Drug _____ Dose/Frequency_____ Drug_____ Dose/Frequency _____

Drug _____ Dose/Frequency_____ Drug_____ Dose/Frequency _____

☐ List additional drugs on back of questionnaire

☐ I take no medications, vitamins, herbals, or any other over-the-counter preparations

Allergies

Name_____ Reaction You Had _____

☐ I have no known **drug** allergies

FAMILY MEDICAL HISTORY

Please indicate if **YOUR FAMILY** has a history of the following: ***(ONLY** include parents, grandparents, siblings, and children)*

- ☐ I am adopted and do not know biological family history
- ☐ Family History Unknown
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anesthetic Complication
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Problems
- ☐ Bleeding Disease
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Lung/Respiratory Disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Other Cancer
- ☐ Rectal Cancer
- ☐ Seizures/Convulsions
- ☐ Severe Allergy
- ☐ Stroke/CVA of the Brain
- ☐ Thyroid Problems
- ☐ NONE of the Above
- ☐ Mother, Grandmother, or Sister developed heart disease before the age of 65
- ☐ Father, Grandfather, or Brother developed heart disease before the age of 55

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

SOCIAL HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Exercise

Do you exercise? ☐ Y ☐ N

If yes, how many minutes per week?_____

Diet

Are you dieting? ☐ Y ☐ N If yes, are you on a physician prescribed medical diet? ☐ Y ☐ N

# 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? ☐ Y ☐ N

If yes, what kind?_____ How many drinks per week?_____

Are you concerned about the amount you drink? ☐ Y ☐ N

Have you considered stopping? ☐ Y ☐ N

Have you ever experienced blackouts? ☐ Y ☐ N

Are you prone to "binge" drinking? ☐ Y ☐ N

Do you drive after drinking? ☐ Y ☐ N

Tobacco

Do you use tobacco? ☐ Y ☐ N

☐ Cigarettes – pks./day_____ **or** pks./week _____ ☐ Chew - #/day_____ ☐ Pipe - #/day_____ ☐ Cigars - #/day_____

☐ # of years_____ ☐ Previous tobacco user - year quit _____

Drugs

Do you currently use recreational or street drugs? ☐ Y ☐ N

Have you ever given yourself street drugs with a needle? ☐ Y ☐ N

☐ I prefer to discuss with the physician

Sex

Are you sexually active? ☐ Y ☐ N

If yes, are you and your partner trying for a pregnancy? ☐ Y ☐ N

If not trying for a pregnancy list contraceptive or barrier method used:_____

Any discomfort with intercourse? ☐ Y ☐ N

Illness related to 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? ☐ Y ☐ N

Mental Health

Is stress a major problem for you? ☐ Y ☐ N

Do you feel depressed? ☐ Y ☐ N

Do you panic when stressed? ☐ Y ☐ N

Do you have problems with eating or your appetite? ☐ Y ☐ N

Do you cry frequently? ☐ Y ☐ N

Have you ever attempted suicide? ☐ Y ☐ N

Have you ever seriously thought about hurting yourself? ☐ Y ☐ N

Do you have trouble sleeping? ☐ Y ☐ N

Have you ever been to a counselor? ☐ Y ☐ N

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

Personal Safety

Do you live alone? ☐ Y ☐ N

Do you have frequent falls? ☐ Y ☐ N

Do you have vision or hearing loss? ☐ Y ☐ N

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? ☐ Y ☐ N

How often do you have sun exposure? ☐ Occasionally ☐ Frequently ☐ Rarely

Have you ever experienced a sunburn? ☐ Y ☐ N

How often do you wear your seatbelt? ☐ Occasionally ☐ Frequently ☐ Always

These questions are for WOMEN ONLY

Age at onset of menstruation:_____ Date of last menstruation:_____ Period every_____days

Heavy periods, irregularity, spotting, pain, or discharge? ☐ Y ☐ N

Number of pregnancies:_____ Number of live births:_____

Are you pregnant or breastfeeding? ☐ Y ☐ N

Have you had a D&C, hysterectomy, or Cesarean? ☐ Y ☐ N

Any urinary tract, bladder, or kidney infections within the last year? ☐ Y ☐ N

Any blood in your urine? ☐ Y ☐ N

Any problems with control of urination? ☐ Y ☐ N

Any hot flashes or sweating at night? ☐ Y ☐ N

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? ☐ Y ☐ N

Do you perform monthly breast self exams? ☐ Y ☐ N

Experienced any recent breast tenderness, lumps, or nipple discharge? ☐ Y ☐ N

Date of last papsmear or pelvic exam:_____

These questions are for MEN ONLY

Do you usually get up to urinate during the night? ☐ Y ☐ N

Do you feel pain or burning with urination? ☐ Y ☐ N

Any blood in your urine? ☐ Y ☐ N

Do you feel burning discharge from penis? ☐ Y ☐ N

Has the force of your urination decreased? ☐ Y ☐ N

Have you had any kidney, bladder, or prostrate infections within the last 12 months? ☐ Y ☐ N

Do you have any problems emptying your bladder completely? ☐ Y ☐ N

Any difficulty with erection or ejaculation? ☐ Y ☐ N

Any testicle pain or swelling? ☐ Y ☐ N

Date of last prostate and rectal exam:_____

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

Other Information

Your healthcare provider needs to know:

Do you have Advanced Directives? *(Advance Directives refer to a person's instructions about future medical care, in the event the person becomes unable to speak for himself/herself. A Living Will is an example of an Advance Directive.)*..... ☐ Y ☐ N

If no, would you like additional details about Advanced Directives? ..... ☐ Y ☐ N

Do you have any religious or cultural beliefs that may impact your healthcare? ..... ☐ Y ☐ N

If yes, please describe:_____

I best learn new information by: ☐ Verbal instructions ☐ Written instructions ☐ Pictures

Level of education completed: ☐ Less than High School ☐ High School diploma or GED ☐ 1-4 years of college ☐ > 4 years of college

I understand English well? ☐ Y ☐ N If no, what language do you prefer?_____

Please circle any symptoms you are currently experiencing or symptoms you have frequently experienced in the past.

Fever Chills	Feeling poorly Feeling tired/fatigued	Recent weight gain Recent weight loss	
Eye pain Red eyes	Eyesight problems Discharge from eyes	Dry eyes Eyes itch	Vision changes
Earache Loss of hearing	Nosebleeds Discharge from nose	Sore throat Hoarseness	Ringing in ears Sinus problems
Chest pain Palpitations	Fast/slow heartbeat Cold hands/feet	Muscle pain Swelling in legs	History of heart murmur History of heart attack
Shortness of breath Wheezing	Cough Shortness of breath with activity	Difficulty breathing while lying down/sleeping	Coughing up phlegm/blood
Abdominal pain Vomiting	Constipation Diarrhea	Heartburn Black, tarry stools	Blood per rectum
Pain with urination Urinary incontinence	Frequent urination at night		Urinary frequency
Muscle/joint pain	Joint swelling Joint stiffness	Limb pain	Back pain
Skin lesions Skin wound	Itching Change in mole		Nail discoloration/deformity
Confusion Convulsions/seizures	Dizziness Fainting	Limb weakness Difficulty walking	Numbness/tingling Frequent falls
Suicidal Sleep disturbances	Anxiety Depression	Change in personality Emotional problems	
Decreased libido/sexual desire		Deepening of voice	Hair loss
Easy bleeding or bruising	Swollen glands		

Other symptoms: _____

_____

Patient's Signature:_____ Date:_____

Reviewed By: _____ Date:_____