



# HEALTH HISTORY QUESTIONNAIRE

Please bring this completed form to your St John's Internal Medicine Appointment

Answer each question by printing the necessary information. Your answers are confidential as protected by Federal HIPPA regulations.

### PERSONAL INFORMATION:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address : \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

In case of emergency, please notify:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### MEDICAL INFORMATION:

Primary Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you under the care of a physician, chiropractor, or other health care professional? Yes  No

If yes, list reason: \_\_\_\_\_

Are you taking any medications? Yes  No  ALLERGIES: \_\_\_\_\_

Please describe any medical diagnoses and medications prescribed:

<i>Diagnosis</i>	<i>Drug</i>	<i>Dosage</i>	<i>Frequency</i>	<i>Diagnosis</i>	<i>Drug</i>	<i>Dosage</i>	<i>Frequency</i>
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

### PAST SURGICAL HISTORY:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### IMMUNIZATION HISTORY:

Hep B series given \_\_\_\_\_ Titers checked \_\_\_\_\_

Last ppd: \_\_\_\_\_ If PPD positive, X-ray or treatment: \_\_\_\_\_

MMR Titer Results \_\_\_\_\_, Tetanus \_\_\_\_\_, Seasonal Flu \_\_\_\_\_ H1N1 \_\_\_\_\_

**SOCIAL HISTORY:**

Do you have a spouse or domestic partner?  
Children (yours or your spouses)?

Yes  No   
Yes  No

To what degree do you perceive your environment as stressful?

**Work:**  Minimal  Moderate  Average  Extremely  
**Home:**  Minimal  Moderate  Average  Extremely

Do you work more than 40 hours a week? \_\_\_\_\_

Do you or have you ever smoked tobacco products?

Non-user  Former user (quit: \_\_\_\_\_)  Cigar and/or pipe  
 1/2 pack per day  1 pack per day  More than 1 pack per day

How much alcohol do you consume in the average week? \_\_\_\_\_

Do you need alcohol or drug counseling? Yes  No

**FAMILY MEDICAL HISTORY:**

Diabetes Type I	<input type="checkbox"/>	Cancer (Type):	<input type="checkbox"/> _____
Type II	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Hyperlipidemia	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	Early Heart Disease	<input type="checkbox"/>

**MUSCULOSKELETAL INFORMATION:**

*Please describe and date any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain, or general discomfort:*

Head / Neck: \_\_\_\_\_  
Upper Back: \_\_\_\_\_  
Shoulder / Clavicle: \_\_\_\_\_  
Arm / Elbow: \_\_\_\_\_  
Wrist / Hand: \_\_\_\_\_  
Lower Back: \_\_\_\_\_  
Hip / Pelvis: \_\_\_\_\_  
Thigh / Knee: \_\_\_\_\_  
Lower Leg / Ankle / Foot: \_\_\_\_\_

**NUTRITIONAL INFORMATION:**

Do you eat a balanced diet? \_\_\_\_\_

Are you on any specific food / nutritional plan at this time? Yes  No  **WHAT:** \_\_\_\_\_

Have you experienced a recent weight gain or loss? Yes  No  Change: \_\_\_\_\_ Over how long?

**EXERCISE HABITS:**

*Please check the box that best describes your work and exercise habits:*

- |   |  |
|---|--|
| <input type="checkbox"/> Intense occupational and recreational exertion   | <input type="checkbox"/> Sedentary work and moderate recreational exertion |
| <input type="checkbox"/> Moderate occupational and recreational exertion  | <input type="checkbox"/> Sedentary work and light recreational exertion    |
| <input type="checkbox"/> Sedentary work and intense recreational exertion | <input type="checkbox"/> Complete lack of all exertion                     |

**Are you currently involved in a regular exercise program?** Yes  No

**Do you regularly walk or run 1 or more miles continuously?** Yes  No

*If yes, what is the average number of miles you cover in a workout? \_\_\_\_\_*

*What is your average time per mile? \_\_\_\_\_*

**Do you practice weightlifting?** Yes  No

**Are you involved in an aerobics program?** Yes  No

*If yes, what type(s)? \_\_\_\_\_*

**What activities would you prefer in a regular exercise program for yourself?**

\_\_\_\_\_

**Do you have a bone/joint problem that has been or could be made worse by exercise?** Yes  No

**Are you unaccustomed to vigorous exercise?** Yes  No

**Is there any reason not mentioned here why you can not follow a regular exercise program?** Yes  No

*If so, please explain \_\_\_\_\_*

***Please circle any medical conditions you have or have had:***

High blood pressure	Glaucoma
Coronary Artery Disease	Depression
Angina	Immune disorder
Heart Attack	Transient Ischemic Attack (TIA)
Heart Murmur	Cerebrovascular Accident (Stroke)
Cardiac Arrhythmia	Seizures Deep Venous Thrombosis
Diabetes	Abdominal Aortic Aneurysm
High Cholesterol	Tuberculosis
Asthma/Bronchitis	Diverticulosis/Diverticulitis
Emphysema	Hepatitis
Multiple Sclerosis	Padget's Disease
Parkinson's Disease	Anemia
Heart Failure / CHF	Osteoarthritis
Mitral Valve Prolapse	Leukemia/Cancer
Multiple Sclerosis	Kidney Stones
Thyroid Disease	

**REVIEW OF SYSTEMS** (Check all that apply)

<p><b>General</b>          Anorexia          Chills          Fatigue          Fever          Malaise          Sweats          Weight Loss</p>	<p><b>Eyes</b>          Blurred Vision          Double Vision          Eye Pain          Eye Discharge          Vision Loss          Eye Irritation</p>
<p><b>Ears, Nose, and Throat</b>          Decreased Hearing          Ringing in Ears          Ear Pain          Hoarseness          Pain with Swallowing          Nose Bleeds</p>	<p><b>Respiratory</b>          Cough          Wheezing          Bloody Sputum          Shortness of Breath</p>
<p><b>Cardiovascular</b>          Chest Pain          Peripheral Edema          Palpitations</p>	<p><b>Musculoskeletal</b>          Joint Pain/Swelling</p>
<p><b>Gastrointestinal</b>          Abdominal Pain          Nausea          Vomiting          Diarrhea          Constipation          Tarry Stools          Bloody Stools</p>	<p><b>Genitourinary</b>          Painful Urination          Blood in Urine          Sexual Dysfunction          Difficulty Voiding          Urinary Incontinence</p>
<p><b>Skin</b>          Dryness          Itching          Rash          Suspicious Lesion</p>	<p><b>Neurological</b>          Dizziness          Weakness          Tremors          Seizures</p>
<p><b>Psychiatric</b>          Depression          Anxiety          Memory Loss          Hallucinations</p>	<p><b>Endocrine</b>          Cold Intolerance          Heat Intolerance          Increased Thirst          Weight Change          Hematologic and          Lymphatic          Abnormal Bruising or bleeding</p>

**ADVANCE DIRECTIVE**

Do you have an advanced directive? Where is a copy stored? \_\_\_\_\_

**CERTIFICATION**

The above information is true to the best of my knowledge.

SIGNED: \_\_\_\_\_  
Name

PRINTED: \_\_\_\_\_  
Name

DATE: \_\_\_\_\_

**REVIEWED BY MEDICAL PROVIDER**

SIGNED: \_\_\_\_\_  
Name

PRINTED: \_\_\_\_\_  
Name

DATE: \_\_\_\_\_