Lake Acworth Family Practice
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# HEALTH HISTORY QUESTINNAIRE

| **TODAYS DATE:** | **DOB:** ☐ M ☐ F |
|---|---|

**Name** *(Last, First, M.I.):*

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

| **Previous or referring provider:** | **Date of last physical exam:** |
|---|---|

## PERSONAL HEALTH HISTORY

**Childhood illness:** ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

**Immunizations and dates:**

| | |
|---|---|
| ☐ Tetanus | ☐ Pneumonia |
| ☐ Hepatitis | ☐ Chickenpox |
| ☐ Influenza | ☐ MMR *Measles, Mumps, Rubella* |

**List any medical problems that other doctors have diagnosed**

**Surgeries & Hospitalizations**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |

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

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

| Name the Drug | Strength | Frequency Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Allergies to medications**

| Name the Drug | Reaction You Had |
|---|---|
| | |
| | |
| | |

## HEALTH HABITS AND PERSONAL SAFETY

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

**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 | ☐ Hi | ☐ Med | ☐ Low | | |
| | Rank fat intake | ☐ Hi | ☐ Med | ☐ Low | | |
| **Caffeine** | ☐ None | ☐ Coffee | ☐ Tea | ☐ Cola | | |
| | # 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 – Packets/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 |
| **Sex** | Are you sexually active? | | | | ☐ Yes | ☐ No |
| | If yes, are you trying for a pregnancy? | | | | ☐ Yes | ☐ No |
| | If not trying for a pregnancy list contraceptive or barrier method used: | | | | | |
| | Any discomfort with intercourse? | | | | ☐ Yes | ☐ No |
| | Illness related to the 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? | | | | ☐ Yes | ☐ No |
| **Personal Safety** | 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

| | AGE | SIGNIFICANT HEALTH PROBLEMS | | AGE | SIGNIFICANT HEALTH PROBLEMS |
|---|---|---|---|---|---|
| **Father** | | | **Children** | ☐ M ☐ F | |
| **Mother** | | | | ☐ M ☐ F | |
| **Sibling** | ☐ M ☐ F | | | ☐ M ☐ F | |
| | ☐ M ☐ F | | | ☐ M ☐ F | |
| | ☐ M ☐ F | | **Grandmother** *Maternal* | | |

| Sibling | ☐ M<br>☐ F | | **Grandfather**<br>*Maternal* | | |
|---|---|---|---|---|---|
| | ☐ M<br>☐ F | | **Grandmother**<br>*Paternal* | | |
| | ☐ M<br>☐ F | | **Grandfather**<br>*Paternal* | | |

## MENTAL HEALTH

| Question | | |
|---|---|---|
| Is stress a major problem for you? | ☐ Yes | ☐ No |
| Do you feel depressed? | ☐ Yes | ☐ No |
| Do you panic when stressed? | ☐ Yes | ☐ No |
| Do you have problems with eating or your appetite? | ☐ Yes | ☐ No |
| Do you cry frequently? | ☐ Yes | ☐ No |
| Have you ever attempted suicide? | ☐ Yes | ☐ No |
| Have you ever seriously thought about hurting yourself? | ☐ Yes | ☐ No |
| Do you have trouble sleeping? | ☐ Yes | ☐ No |
| Have you ever been to a counselor? | ☐ Yes | ☐ No |

## OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

| | | |
|---|---|---|
| ☐ Visual Changes/Loss | ☐ Shortness of breath | ☐ Changes in muscle strength |
| ☐ Head Injury | ☐ Asthma or Emphysema | ☐ Falling |
| ☐ Headaches | ☐ High blood pressure | ☐ Hepatitis A, B or C |
| ☐ Seizures | ☐ Chest pain, heart attack | ☐ Sexually Transmitted Infections |
| ☐ Hearing Loss | ☐ Constipation or Diarrhea | ☐ Elevated cholesterol or glucose levels |
| ☐ Nose | ☐ Difficulty controlling bowel or bladder | ☐ Diabetes |
| ☐ Throat | ☐ GYN problems | ☐ Memory problems |
| ☐ Thyroid disorder | ☐ Cancer/Tumors/Cysts | ☐ Difficulty with sleep |
| ☐ Allergies | ☐ Back Pain | ☐ Childhood Illness - specify |
| ☐ Recent Weight Changes | ☐ Other pain: | ☐ Other chronic health issues: |

## OTHER CONCERNS

Please use the space below to share any other concerns:

## PROVIDER'S COMMENTS