Waterfall Community
Health Center
Health History Questionnaire

ALL QUESTIONS CONTAINED IN THIS QUESTIONAIRE ARE STRICTLY CONFIDENTIAL AND WILL BECOME PART OF YOUR ELECTRONIC MEDICAL RECORD

Date:
Reviewed By & Date:

Patient MRN: _____

Name: (Last, First, M.I.)	( ) M ( ) F	**DOB:**
Marital Status: ( ) Single ( ) Partnered ( ) Married ( ) Separated ( ) Divorced ( ) Widowed		
Previous Care Provider or Referring Provider:		**Date of Last Physical:**

Personal Health History

Childhood Illness: ( ) Measles ( ) Mumps ( ) Rubella ( ) Chickenpox ( ) Rheumatic Fever ( ) Polio

Immunizations and Dates:	( ) Tetanus ( ) Hepatitis B ( ) Influenza	( ) Pneumonia ( ) Chickenpox ( ) Shingles ( ) MMR (Measles, Mumps and Rubella)

List all medications (Including prescriptions, herbals, and over the counter drugs such as VITAMINS & INHALERS)

NAME OF MEDICATION	STRENGTH	FREQUENCY TAKEN

Current Pharmacy Provider and City:

List all allergies to medications, foods, contrast, and dyes (continue on back if more space is needed)

Mark ALL medical problems that other Doctors or care providers have diagnosed you with

( ) Allergies	( ) Anemia	( ) Anxiety	( ) Alcoholism
( ) Arthritis	( ) Asthma	( ) Blood Transfusion	( ) Bleeding Problems
( ) Cancer	( )Cataracts	( ) CHF – Heart Failure	( ) Breast Lumps
( ) Clotting Disorder	( ) COPD	( ) Depression	( ) Cirrhosis (Liver)
( ) Diabetes	( ) Emphysema	( ) GERD/Reflux	( ) Fibromyalgia
( ) Glaucoma	( ) Heart Murmur	( ) HIV/AIDS	( ) Sexually Transmitted infection
( ) High Blood Pressure	( ) Kidney Disease	( ) Meningitis	( ) Gallbladder Disease
( ) Heart Attack	( ) Nerve/Muscle Disease	( ) Osteoporosis	( ) Hepatitis
( ) Seizures	( ) Sickle Cell Anemia	( ) Stroke	( ) Incontinence
( ) Substance Abuse	( ) Thyroid Disease	( ) Tuberculosis	( ) Irregular Heart Rate
( ) Kidney Failure	( ) Mental Illness	( ) Migraines/Headaches	( ) Skin problems
( ) Ulcers	( ) Fracture/Joint surgery		

Surgeries: (tonsils, appendix, C-section, joints, tubal ligation, fracture repair)		
Year	**Reason/type of surgery**	**Hospital, city and state**

Have you ever had a blood transfusion (received blood)? **( ) Yes** **( ) No**

Health Habits and safety

Alcohol	Do you drink alcohol?		( ) Yes	( ) No
	If yes, what kind?			
	On average, 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 __ Packs per day	( ) Chew__ cans per day	( ) Cigars __ per day	
	How many years? **OR**	**Year you quit:**		
Drugs	Do you currently use recreational or street drugs? (Marijuana, heroin, meth, etc.)		( ) Yes	( ) No
	Have you ever given yourself street drugs using a needle?		( ) Yes	( ) No
Sex	Are you sexually active?		( ) Yes	( ) No
	If yes, are you trying for pregnancy?		( ) Yes	( ) No
	If not trying for pregnancy, list contraceptives/barrier methods you use:			
	Any discomfort during intercourse?		( ) Yes	( ) No
	Unprotected sex & IV drug use are risk factors for HIV/AIDS. Would you like to discuss your risk of these illnesses with your provider?		( ) Yes	( ) No
Personal Safety	Do you live alone? ( ) Yes ( ) No	Do you fall frequently?	( ) Yes	( ) No
	Do you have vision loss? ( ) Yes ( ) No	Do you have hearing loss?	( ) Yes	( ) No
	Do you have an Advanced Directive or Living Will?		( ) Yes	( ) No
	Physical/mental abuse often takes the form of verbal threats and/or actual physical or sexual abuse. Would you like to discuss this issue with your provider?		( ) Yes	( ) No
	Are you being abused?		( ) Yes	( ) No
	Are you homeless? ( ) Yes ( ) No	Are you on food stamps?	( ) Yes	( ) No

Family Health History

Age or age at death		Significant health problems	Age or age at death		Significant health problems
Father:	( )Alive ( )Deceased		Children (indicate male or female)	( )Alive ( )Deceased	
Mother:	( )Alive ( )Deceased			( )Alive ( )Deceased	
Siblings (please indicate male or female)	( )Alive ( )Deceased			( )Alive ( )Deceased	
	( )Alive ( )Deceased			( )Alive ( )Deceased	
	( )Alive ( )Deceased		Maternal grandmother	( )Alive ( )Deceased	
	( )Alive ( )Deceased		Maternal grandfather	( )Alive ( )Deceased	
	( )Alive ( )Deceased		Paternal grandmother	( )Alive ( )Deceased	
	( )Alive ( )Deceased		Paternal grandfather	( )Alive ( )Deceased	

Problem	Mother	Father	Sister*			Brother*			Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Children			
													M		F	
Alcohol/drug abuse																
Allergies																
Arthritis																
Asthma																
Bleeding/blood problems																
Cancer																
COPD																
Depression																
Diabetes																
Gastrointestinal problems																
Genetic diseases/birth defects																
Genitourinary																
Headaches																
Heart Problems																
High Cholesterol																
Hypertension																
Kidney Disease																
Mental illness																
Musculoskeletal disorders																
Nervous system disorder																
Obesity																
Osteoporosis																
Sickle cell anemia																
Stroke																
Thyroid																
Tuberculosis																
Vision Problems																

***MARK SIBLINGS LEFT TO RIGHT OLDEST TO YOUNGEST**

Activities of Daily Living and Concerns

	Yes	No	Comments
Military? If yes, which branch?			
Any caffeine concerns?			
Any hobby hazards (home)?			
Any stress concerns?			
Are you currently on a special diet?			
Any exercise concerns?			
Do you wear a seatbelt?			
Have you ever had a blood transfusion?			
Any occupational (work) hazards?			
Any sleep concerns?			
Any weight concerns?			
Any back care concerns?			
If you bike, do you wear a helmet?			
Do you perform any self-exams?			

SYMPTOMS		
Please CHECK ALL items which apply to your health during the PAST 6 MONTHS		
If NONE check here ( )		
Head, ears, eyes, nose, mouth, and throat:	**Gastrointestinal tract:**	**Musculoskeletal:**
( ) Blurred vision	( ) Loss of appetite	( ) Joint pain
( ) Ringing in ears	( ) Nausea	( ) Joint swelling
( ) Hearing difficulties	( ) Heartburn	( ) Lower back pain
( ) Mouth sores	( ) Indigestion or belching	( ) General back pain
( ) Loss or change in taste	( ) Pain/discomfort in upper abdomen or stomach	( ) Neck pain
( ) Difficulty chewing/swallowing	( ) Other abdominal pain	( ) Muscle pain
( ) Headache	( ) Constipation or diarrhea (circle)	( ) Muscle weakness
( ) Dizziness	( ) Hemorrhoids/rectal bleeding	( ) Morning muscle/joint stiffness
( ) Fever	( ) Black tarry stools	( ) Decreased muscle control
( ) Voice change or persistent hoarseness		
Chest, lungs, and heart	**Neurologic and psychologic**	**Skin**
( ) Chest pain	( ) Depression or anxiety	( ) Easy bruising
( ) Shortness of breath	( ) Insomnia	( ) Hives or welts
( ) Wheezing (asthma)	( ) Tiredness (Fatigue)	( ) Itching
( ) Pneumonia	( ) Trouble thinking or remembering	( ) Rash
WOMEN ONLY		
Age of onset of menstruation:		
Date of last menstruation:		
Number of pregnancies: _____ Number of live births: _____		
Date of last mammogram? _____		
Date of last pap and rectal exam? _____		