TRI-VALLEY MEDICAL CENTER, INC.

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE- PRIMARY CARE

Welcome to our office. All the following questions contained in this questionnaire are strictly confidential and will become part of your medical record. Please answer to the best of your knowledge. These questions will assist us in your comprehensive and efficient medical care.

Name *(Last, First, M.I.):* ☐ M ☐ F		**DOB:**
Marital status: ☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐ Widowed		
Previous or referring doctor:	**Date of; Last physical exam:** **Last chest X-ray:**	**Last Blood test:** **Usual weight:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐Mumps ☐Rubella ☐Chickenpox ☐Rheumatic Fever ☐ Polio			
Immunizations and dates:	☐ Tetanus	☐ Pneumonia	
	☐ Hepatitis	☐ Chickenpox	
☐ Influenza	☐ MMR *Measles, Mumps, Rubella*		

Circle any medical problems that other doctors have diagnosed

AID/HIV	Diverticulosis	Psychiatric Care	Tonsilitis
Alcoholism	Drug Dependency	Rheumatic Fever	Tuberculosis
Anemia	Fibromyalgia	Scarlet Fever	Typhoid Fever
Anorexia/Bulemia	Gout	Stroke	Vaginal infection
Appendicitis	Diabetes	Hernia	Venereal Disease
Arthritis	Hay Fever/Allergies	Ulcers	Other Illness:
Asthma	Heart Disease	High Cholesterol	
Bleeding Disorders	Hepatitis	Hormone Therapy	
Blood transfusions	High Blood Pressure	Measels	
Breast lump	Gall Bladder Disease	Migraine	
Cancer	Kidney disease	Mononucleosis	
Cataracts	Glaucoma	Pacemaker	
Chicken Pox	Head Injury	Pneumonia	
Colitis	Multiple Sclerosis	Prostate problems	
Congenital Disorders	Polio	Seizures	
Depression	Psoriasis	Suicide Attempt	

Surgeries

Year	Reason	Hospital

Other 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 – pks./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*			
☐ M ☐ F		**Grandfather** *Maternal*			
☐ M ☐ F		**Grandmother** *Paternal*			
☐ M ☐ F		**Grandfather** *Paternal*			

MENTAL HEALTH

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

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam? Date of Last Mammogram:		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

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

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

X_____ Date_____

Thank you very much for completing the information on this form and providing us with pertinent information for your care.