JALH PHYSICIAN CLINICS

HEALTH HISTORY QUESTIONNAIRE

PATIENT NAME____ DOB_______________________________

REASON FOR YOUR VISIT TODAY____

PLEASE LIST ALL PAST SURGICAL HISTORY AND DATES:
1.___________________________________ DATE_____________ 2.____ DATE_____________
3.___________________________________ DATE_____________ 4.____ DATE_____________
5.___________________________________ DATE_____________ 6.____ DATE_____________
7.___________________________________ DATE______________ 8.____ DATE_____________

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING AND THE DOSAGE?

____ ____
____ ____
____ ____
____ ____

HAVE YOU HAD A FLU SHOT THIS YEAR? YES OR NO HAVE YOU EVER HAD A GARDASIL SHOT? YES OR NO

WHAT PHARMACY DO YOU USE?__________________________________ CITY____
WHO IS YOUR PRIMARY CARE DOCTOR?____
ALLERGIES:____

HAVE YOU EVER BEEN DIAGNOSED BY A PHYSICAN WITH ANY OF THE FOLLOWING:

ANEMA	Y/N	ENDOMETRIOSIS	Y/N
ANESTHIA COMPLICATIONS	Y/N	GI PROBLEMS	Y/N
ANXIETY	Y/N	HEADACHES/MIGRAINES	Y/N
ARTHRITIS	Y/N	HEART CONDITIONS	Y/N
ASTHMA	Y/N	HEART DISEASE	Y/N
BIRTH DEFECTS/INHERITED DISEASE	Y/N	HYPERTENSION	Y/N
BREAST PROBLEMS	Y/N	INFERTILITY	Y/N
CANCER	Y/N	KIDNEY/BLADDER PROBLEMS	Y/N
CANCER, BREAST	Y/N	LUNG DISEASE	Y/N
CANCER, CERVICAL	Y/N	OSTEOPENIA	Y/N
CANCER,OVARIAN	Y/N	OSTEOPOROSIS	Y/N
CANCER, UTERINE	Y/N	PSYCHIATRIC ILLNESS	Y/N
DIABETES	Y/N	THYROID PROBLEMS	Y/N

FAMILY MEDICAL HISTORY
HAS ANYONE IN YOUR FAMILY EVER HAD BREAST, COLON, OVARIAN, OR UTERINE CANCER? Y/N RELATIONSHIP TO YOU_______________ WHAT AGE________
HAS ANYONE IN YOUR FAMILY EVER HAD A CHILD BORN WITH ANY CONGENTIAL ABNORMALITIES? Y/N
SICKLE CELL DISEASE Y/N CYSTIC FIBROSIS Y/N MENTAL RETARDATION Y/N OTHER____________________

PAST PREGNANCIES (PLEASE TELL US ABOUT YOUR CHILDREN)
BIRTH DATE:___________________ BIRTH WEIGHT_______________ SEX M/F DELIVERY TYPE: VAGINAL OR C-SECT DOCTOR__________________
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AT WHAT AGE DID YOU START YOUR PERIOD?___________ HOW MAY DAYS IS YOUR CYCLE EACH MONTH?______________________
WHEN WAS YOUR LAST PAP SMEAR?_______________ HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR? Y/N IF SO, WHERE____________________
WHEN WAS YOUR LAST MAMMOGRAM?________________ HAVE YOU EVER HAD AN ABNORMAL MAMMOGRAM? Y/N IF SO, WHERE___________________
HAVE YOU EVER HAD A COLONOSCOPY? Y/N IF SO, WHEN_________________ BY WHOM____________________________
WHAT IS YOUR CURRENT METHOD OF BIRTH CONTROL? _______________ DO YOU THINK YOU MIGHT BE PREGNANT TODAY?________________
HAVE YOU HAD CURRENT BLOOD WORK? Y/N IF SO, WHERE?____

WHAT IS YOUR LEVEL OF EDUCATION: HIGH SCHOOL COLLEGE OTHER_____________ OCCUPATION________________________
DO YOU CURRENTLY SMOKE? Y/N IF SO, HOW MUCH?___________________ HOW LONG?__________________ DO YOU TAKE RECREATIONAL DRUGS? Y/n
DO YOU DRINK ALCHOHOL? Y/N IF SO, HOW MUCH?___________________ HOW MUCH CAFFEINE DO YOU HAVE A DAY?_________________