ASCENSION Medical Group

HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important.
ALL QUESTIONS ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Preferred Name: _____ Preferred Pronouns: _____
Main reason for today's visit: _____

ALLERGIES

List everything you are allergic to (medications, food, bee stings, latex, etc.) and how each affects you.

ALLERGY	REACTION
1._____	_____
2._____	_____

MEDICATIONS

Please list all the medications you are taking, including over-the-counter drugs, such as vitamins.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

OBSTETRIC AND GYNECOLOGICAL HISTORY (women only)

Last PAP Smear Date _____ ❑ Abnormal
Last Mammogram Date _____ ❑ Abnormal
Age of first menstrual period: _____
Date of last menstrual period or age of menopause: _____
Number of pregnancies: _____ births: _____ miscarriages: _____ abortions: _____
❑ Cesarean sections If yes, then number: _____

Please check all that apply:

- ❑ Bleeding between periods
- ❑ Heavy periods
- ❑ Extreme menstrual pain
- ❑ Vaginal itching, burning, or discharge
- ❑ Sexually active
  - Current sexual partner is: ❑Female ❑Male
  - Do you use condoms: ❑Yes ❑No
  - Other Birth control method used:_____
- ❑ Interested in being screened for STDs
- ❑ Wake in the night to go to the bathroom
- ❑ Hot flashes
- ❑ Breast lump or nipple discharge
- ❑ Painful intercourse

HITS Tool for Intimate Partner Violence Screening:
Please fill in the circle that best describes how your partner treats you:

How often does your partner?	Never	Rarely	Sometimes	Fairly often	Frequently
1. Physically hurt you	O	O	O	O	O
2. Insult or talk down to you	O	O	O	O	O
3. Threaten you with harm	O	O	O	O	O
4. Scream or curse at you	O	O	O	O	O
	1	**2**	**3**	**4**	**5**

PAST MEDICAL HISTORY

Please check all that apply:

- ❑ Anxiety Disorder
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Blood Clots (or DVT)
- ❑ Cancer
- ❑ Coronary Artery Disease
- ❑ Claustrophobic
- ❑ Diabetes - Insulin
- ❑ Diabetes - Non-Insulin
- ❑ Dialysis
- ❑ Diverticulitis
- ❑ Fibromyalgia
- ❑ Gout
- ❑ Have a Pacemaker
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Hiatal Hernia or Reflux Disease
- ❑ HIV or AIDS
- ❑ High Cholesterol
- ❑ High Blood Pressure
- ❑ Overactive Thyroid
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Leg/Foot Ulcers
- ❑ Liver Disease
- ❑ Osteoporosis
- ❑ Polio
- ❑ Pulmonary Embolism
- ❑ Reflux or Ulcers
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Other: _____

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1. _____	_____	_____	_____
2. _____	_____	_____	_____

FAMILY HEALTH HISTORY

RELATION	**ALIVE?**	**AGE**	**Significant Health Problems** (circle all that apply)
Grandmother (maternal)	Y/N	_____	❑Cancer ❑Heart disease ❑Hypertension ❑Stroke
Grandfather (maternal)	Y/N	_____	❑Cancer ❑Heart disease ❑Hypertension ❑Stroke
Grandmother (paternal)	Y/N	_____	❑Cancer ❑Heart disease ❑Hypertension ❑Stroke
Grandfather (paternal)	Y/N	_____	❑Cancer ❑Heart disease ❑Hypertension ❑Stroke
Father	Y/N	_____	❑Cancer ❑Heart disease ❑Hypertension ❑Stroke
Mother	Y/N	_____	❑Cancer ❑Heart disease ❑Hypertension ❑Stroke
Brother/Sister	Y/N	_____	❑Cancer ❑Heart disease ❑Hypertension ❑Stroke
Brother/Sister	Y/N	_____	❑Cancer ❑Heart disease ❑Hypertension ❑Stroke
Other:_____	Y/N	_____	❑Cancer ❑Heart disease ❑Hypertension ❑Stroke

SOCIAL HISTORY

Highest Level of Education:

❑ Less than 8th grade
❑ High school
❑ 2 year college
❑ 4 year college
❑ Post graduate

Exercise Level:

Do you have a regular exercise routine (besides work, like walking, swimming, or biking) that you do for at least 30 minutes, 2-3 days a week?

❑ No, but I intend to start in the next 30 days
❑ No, but I intend to start in the next 6 months
❑ No, and I do not intend to start in the next 6 months
❑ Yes, I have been for longer than 6 months
❑ Yes, but it has been for less than 6 months

- If yes, on average, how many days per week do you engage in moderate to strenuous exercise (like a brisk walk)?
  _____ days.
- On average, how many minutes do you engage in exercise at this level?
  _____ minutes.

Do you have an **Advanced Care Directive** (Durable Power of Attorney for Health Care)?
❑Yes ❑No
If no, would you like more information?
❑Yes ❑No

Do you have any **religious or cultural beliefs** that will affect your care? ❑Yes ❑No
If yes, please describe: _____

Marital Status:

❑ Married
❑ Single
❑ Divorced
❑ Separated
❑ Widowed
❑ Domestic partner

Caffeine:

❑None ❑Occasional
❑Moderate ❑Heavy
# of cups/cans per day?____

Do you drink alcohol? ❑Yes ❑No
If so, how often?
❑Occasionally
❑< 3 times a week
❑> 3 times a week
How many drinks per week? ____

Do you use tobacco? ❑Yes ❑No
If not currently, did you ever use tobacco?
❑Yes ❑No
# of years___ or Year quit _____
Cigarettes -____pks./day
Chew - ____/day
Cigars - _____/day

Do you currently use recreational or street drugs? ❑Yes ❑No
If yes, please list:_____

Fall Risk:

Have you had any falls in the past year?
❑Yes, frequency____ ❑No

_____ _____
Patient, Parent, Guardian, or Caregiver Signature Date