

**GENERAL HEALTH HISTORY QUESTIONNAIRE** (age 13 years or older)

Name: \_\_\_\_\_  
 (LAST) (FIRST) (MI)

Date: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male / Female \_\_\_\_\_ Race \_\_\_\_\_

SIGNIFICANT ILLNESSES		
Do you or have you had: (please circle)		
Diabetes	YES	NO
Cancer	YES	NO
Gout	YES	NO
High Blood Pressure	YES	NO
Heart Disease	YES	NO
Kidney Disease	YES	NO
Mental Illness	YES	NO
Abnormal Pap	YES	NO
Asthma	YES	NO
High Cholesterol	YES	NO
Other Illness not listed: _____		

HOSPITALIZATIONS/SURGERIES	
List all reasons you were hospitalized	Year
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

FAMILY MEDICAL HISTORY		
Has any blood relative, including children, had any of the following:		
		Relationship
Anemia	Y N	_____
Bleeding Tendency	Y N	_____
Cancer	Y N	_____
Diabetes	Y N	_____
Epilepsy	Y N	_____
Heart Disease	Y N	_____
High Cholesterol	Y N	_____
Stroke	Y N	_____
Tuberculosis	Y N	_____
Colon Polyps	Y N	_____

HEALTH SCREENING		
Have you had		Date of Last
Physical	Y N	_____
Pap	Y N	_____
Chest X-ray	Y N	_____
Tetanus Shot	Y N	_____
MMR shot	Y N	_____
TB test	Y N	_____
Mammogram	Y N	_____
EKG	Y N	_____
Colonoscopy	Y N	_____
Hepatitis Vaccine	Y N	_____
Pneumonia Shot	Y N	_____
Bone Density	Y N	_____
Shingles Vaccine	Y N	_____

SOCIAL HISTORY	
Tobacco History	Y N # years _____
Alcohol	Y N Drinks per week _____
Caffeine	Y N Cups/cans per week _____
Recreational	
Drugs	Y N Times per week _____
Exercise	Y N Times per week _____

ALL ALLERGIES (MEDICATIONS/FOODS/ETC)	REACTION
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

MEDICATIONS	
(List all medication you take on a regular basis including over the counter medications)	
1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

Your Pharmacy _____ (example -CVS)	Location _____ (example - Bacon Rd)
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Are you currently having any pain? YES NO

Is it a new pain? YES NO

Do you have chronic (everyday) pain? YES NO

How bad is the pain? (none) 0-1-2-3-4-5-6-7-8-9-10 (very severe)

Please describe the pain: Aching\_\_ Burning\_\_ Cramping\_\_ Dull\_\_ Pressure\_\_ Sharp\_\_  
Shooting\_\_ Squeezing\_\_ Stabbing\_\_ Throbbing\_\_ Other

Please circle anything the pain affects: sleep energy appetite activity mood work relationships

Are you currently taking anything for the pain? YES NO

Are you or have you been in a relationship in which you feel unsafe? YES NO

Have you or your children been hit or threatened? YES NO

Have you fallen in the last 3 months? YES NO

Do you have difficulty walking? YES NO

Do you any problems with imbalance? YES NO

Do you have any of the following Advanced Directives?

Living Will YES NO

DNR (Do Not Resuscitate) YES NO