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Today's Date:	Dates Revised:
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## HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Previous health providers:	Date of last physical exam:	
Place of employment/occupation:		

### PERSONAL HEALTH HISTORY

Childhood illness:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio		
Immunizations and dates:  <input type="checkbox"/> See immunization record	<input type="checkbox"/> Tetanus:	<input type="checkbox"/> Influenza:	<input type="checkbox"/> Gardasil:
	<input type="checkbox"/> Hepatitis A:	<input type="checkbox"/> Pneumonia:	<input type="checkbox"/> Zostavax:
	<input type="checkbox"/> Hepatitis B:	<input type="checkbox"/> Chickenpox:	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i> :

List any medical problems

Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Name: \_\_\_\_\_

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers			<input type="checkbox"/> None
Name the Drug	Strength	Frequency Taken	
<b>Allergies to medications</b>	<input type="checkbox"/> No known drug allergies		
<b>Environmental allergies</b>	<input type="checkbox"/> No known environmental allergies		
<b>Do you have a latex allergy?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**HEALTH HABITS AND PERSONAL SAFETY**

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.			
<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
<b>Diet</b>	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
<b>Caffeine</b>	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola		
	# of cups/cans per day?		
<b>Alcohol</b>	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?	How many drinks per week?	
	Have you ever felt you should cut down on your drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have people annoyed you by criticizing your drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever felt bad or guilty about your drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Tobacco</b>	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day:	<input type="checkbox"/> Chew - #/day:	<input type="checkbox"/> Pipe - #/day: <input type="checkbox"/> Cigars - #/day:
	<input type="checkbox"/> # of years:	<input type="checkbox"/> Or year quit:	

Name: \_\_\_\_\_

<b>Drugs</b>	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Sex</b>	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy, list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Personal Safety</b>	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive, Living Will, Durable Power of Attorney for Healthcare, or State Guardianship? If Yes, please provide us with a copy.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**FAMILY HEALTH HISTORY**

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Mother</b>				<input type="checkbox"/> M <input type="checkbox"/> F	
<b>Sibling</b>	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> <i>Paternal</i>		

**MENTAL HEALTH**

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Name: \_\_\_\_\_

**WOMEN ONLY**

Age at onset of menstruation:	Date of last menstruation:	Period every ____ days
Heavy periods, irregularity, spotting, pain, or discharge?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breastfeeding?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Caesarean?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Any blood in your urine?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Any problems with control of urination?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Any hot flashes or sweating at night?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last mammogram:	Have you ever had an abnormal mammogram?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last Dexascan/bone density test:	Date of last colonoscopy (recommended if over 50):	
Date of last pap and/or rectal exam:	Have you ever had an abnormal pap smear?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**MEN ONLY**

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, # of times ____	
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last prostate and rectal exam? (recommended if over 40):	
Date of last colonoscopy? (recommended if over 50):	

**OTHER PROBLEMS**

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

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	