NORTH MEMORIAL HEALTH | CLINIC

HEALTH HISTORY QUESTIONNAIRE

Legal Name _____ Date of Birth_____ Age _____

Preferred Name _____ Occupation_____

Preferred form of Address: □ He/Him □ She/Her □ They/Them □ Other _____

□ Single □ Married □ Long-term partner □ Divorced □ Widowed Children? □ No □ Yes_____

Do you have an Advanced Directive? □ Yes □ No If No, would you like information? □ Yes □ No

Reason for visit today?_____

Past Medical Problems and Updates

List any chronic diseases, illnesses, hospitalizations or surgeries (include dates):

A._____ E._____
B. _____ F. _____
C._____ G._____
D. _____ H. _____

Allergies (medications, foods, environment): _____

_____

Current Medications

Please include prescription, non-prescription, vitamins, and herbal/supplements. If you have a list please share it with staff.

NAME	STRENGTH	HOW OFTEN

Family History

Please indicate any medical conditions including: diabetes, heart disease, high blood pressure, cancer, lung disease, kidney disease, bleeding concerns, blood clots, stroke, migraine headaches, mental illnesses, alcoholism/chemical abuse, etc

Mother _____
Father _____
Sister(s) _____
Brother(s) _____
Maternal
Grandmother _____
Grandfather _____
Paternal
Grandmother _____
Grandfather _____
Children _____

Over the past two weeks have you been bothered by the following:

1. Little interest or pleasure in doing things:
□ Not at all □ Several Days □ More than half the days □ Nearly every day

2. Feeling down, depressed, or hopeless:
□ Not at all □ Several Days □ More than half the days □ Nearly every day

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LIFESTYLE SCREENING

1. **Do you use Tobacco?** No Yes
   Type: _____
   Amount per day: _____
2. **Do you use Alcohol?** No Yes
   Amount per week: _____
   In the past year, how often have you had more than 4 drinks (women)/5 drinks (men) in a day? _____
3. **How many times in the last year have you used illegal drugs or prescription medications for non-medical reasons?** _____
   Type: _____
4. **Do you use caffeine?** No Yes
   Amount per day: _____
5. **Are you sexually active?** No Yes Birth Control/Protection: _____
   Partners: Male Female Both How many partners in the last year: _____
6. **Do you exercise?** No Yes
   Activity: _____ Minutes: _____ Times per week: _____
7. **Do you follow a special diet?** No Yes _____
8. **Are you safe at home?** Yes No _____

REVIEW OF SYSTEMS

Check any of the following you are currently experiencing or have experienced recently:

SKIN
- □ Rashes
- □ New or changing moles

HEAD
- □ Dizziness
- □ Frequent headaches

EYES
- □ Eye pain
- □ Blurry vision
- □ Double vision
- □ Itchy eyes

EARS
- □ Ringing in ears
- □ Ear pain
- □ Hearing loss

THROAT
- □ Sore throat
- □ Difficulty chewing or swallowing foods
- □ Hoarseness
- □ Swollen glands

MUSCULOSKELETAL
- □ Back pain
- □ Joint pain
- □ Muscle pain
- □ Weakness

LUNGS
- □ Cough
- □ Wheezing
- □ Trouble breathing
- □ Chest tightness
- □ Snoring
- □ Coughing up blood

HEART
- □ Chest pain or pressure
- □ Irregular heartbeat or palpitations
- □ Heart valve problems
- □ Heart murmur
- □ Swollen feet or ankles

ABDOMEN
- □ Bloating
- □ Change in appetite
- □ Heartburn
- □ Nausea/Vomiting
- □ Stomach pain
- □ Constipation
- □ Diarrhea
- □ Hemorrhoids or rectal bleeding
- □ Black colored stools

MOOD/BEHAVIOR
- □ Depression
- □ Anxiety
- □ Trouble concentrating
- □ Drug/alcohol concerns
- □ Gender/Sexuality concerns

NERVES
- □ Fainting spells or blackouts
- □ Numbness or tingling
- □ Seizures
- □ Tremor

URINARY
- □ Pain or burning with urination
- □ Urgency or frequency of urination
- □ Loss of control
- □ Blood in urine

GENERAL
- □ Weight loss or gain
- □ Fatigue
- □ Fever/Chills
- □ Sleep problems
- □ Easy bruising/bleeding

MALES
- □ Erectile dysfunction
- □ Urine flow change
- □ Testicular pain or swelling
- □ Penile discharge

FEMALES
- □ Breast swelling
- □ Breast tenderness
- □ Vaginal discharge
- □ Irregular vaginal bleeding
- □ Heavy vaginal bleeding