Main Street Medical
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HEALTH HISTORY QUESTIONNAIRE

Your complete, detailed responses to this questionnaire will help us to provide you with the best possible health care by learning more about you and your health history. If you have difficulty answering a question, please put a question mark (?) in that space.

Name: _____ Today's date: ____/____/_____

Age: _____ Birthdate: ____/____/_____ How you heard of our practice: _____

PAST HEALTH HISTORY

Please list your current health problems and how long you've had them.

Current health problem	How long present
_____	_____
_____	_____
_____	_____
_____	_____

CIRCLE IF A HEALTH CARE PROVIDER HAS TOLD YOU THAT YOU HAVE ANY OF THESE ILLNESSES

Anemia	Glaucoma	Arthritis or Rheumatism	Asthma
Gout	Stroke	Bleeding tendency	Heart trouble
Thyroid disease	Cancer or tumor	Hepatitis	Tuberculosis
Diabetes	High blood pressure	Ulcer or stomach trouble	Polio
Emphysema or bronchitis	Kidney or bladder trouble	Venereal disease	Seizures (epilepsy)
Rheumatic/scarlet fever	Mononucleosis	Depression or nervous breakdown	

LIST ANY OTHER MAJOR ILLNESSES, OPERATIONS, HOSPITALIZATIONS, MAJOR INJURIES OR OTHER IMPORTANT HEALTH PROBLEMS YOU'VE HAD DURING YOUR LIFE

	YEAR (approximate)
_____	_____
_____	_____
_____	_____

PLEASE LIST ALL ALLERGIES, INCLUDING MEDICATION, FOOD AND MEDICAL SUPPLIES, AND YOUR REACTION

ALLERGY	REACTION	ALLERGY	REACTION
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE GO TO NEXT PAGE

PLEASE LIST ALL MEDICATIONS THAT YOU TAKE, INCLUDING BIRTH CONTROL PILLS AND NON-PRESCRIPTION MEDICATIONS, SUCH AS PAINKILLERS, LAXATIVES, SLEEP AIDS, VITAMINS, ETC.

MEDICINE	FREQUENCY	MEDICINE	FREQUENCY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is birth control one of your concerns? ◯ Y ◯ N If yes, what method do you use? _____

Have you ever had a sexually transmitted disease, such as Syphilis, Gonorrhea, Herpes, Genital Warts or Chlamydia?

◯ Y ◯ N If yes, which one(s)? _____

Do you practice safe sex? ◯ Y ◯ N

When did you have each of the following? If never, write "never":

Complete Physical Exam _____ PAP Smear _____ EKG _____ Cholesterol Check _____

Tetanus Shot _____ Pneumonia Shot _____ Hepatitis B Series _____ TB Test _____

Mammogram _____Bone Mineral Density _____ Colonoscopy _____ Sigmoidoscopy_____

Do you know your blood type? ◯ Y ◯ N If so, what is it? _____

SOCIAL HISTORY

Where were you born? _____ Where did you grow up? _____

Highest level of school completed _____ Current marital status _____

List the sex and ages of any children you have _____

Who, besides you, lives in your current household? _____

Are you responsible for care of an elderly adult? _____

HABITS

Do you exercise regularly? ◯ Y ◯ N If so, state details: _____

_____

Do you smoke? ◯ Y ◯ N If yes, how many packs per day? _____ How many years? _____

If you have quit smoking, how long has it been since you've smoked? _____

Have you ever used illegal drugs? ◯ Y ◯ N If yes, which drugs? _____

Do you drink alcohol? ◯ Y ◯ N If yes, how many drinks do you have in the average week? _____

Do you drink or eat anything with caffeine? ◯ Y ◯ N If yes, how much in the average day? _____

Are you a vegetarian? ◯ Y ◯ N Do you use meditation or relaxation practices? ◯ Y ◯ N

Do you wear a seat belt in automobiles? ◯ Y ◯ N

PLEASE GO TO NEXT PAGE

Please place a check mark (√) if you've had any of the following symptoms within the last year. Leave blank if you're not sure.

HEAD/NECK

Severe headaches ____	Severe hearing loss ____	Chronic nose obstruction ____	Dizzy spells ____
Repeat nosebleeds ____	Ringing in ears ____	Double vision ____	Failing vision ____
Prolonged hoarseness ____	See 'floating lights' ____	Swelling in neck ____	Trouble swallowing___

HEART/LUNGS

Chest pain on effort ____	Sit up to breathe easy ____	Night sweats ____	Palpitations ____
Chronic cough ____	Swollen ankles ____	Difficult breathing ____	Spit up blood ____

STOMACH/INTESTINES

Chronic abdominal pain ____	Vomiting blood ____	Blood in stool ____	Persistent nausea ____
Skin turned yellow ____	Clay colored stool ____	Heartburn ____	Chronic diarrhea ____
Chronic constipation ____	Appetite loss ____	Hemorrhoids ____	Black tarry stool ____

URINARY TRACT

Excess urination ____	Pain with urination ____	Excess night urination ____	Leakage of urine ____
Bedwetting ____	Retention of urine ____	Passed kidney stone(s) ____	Blood in urine ____

MUSCLES/JOINTS/NERVES

Tingling sensations ____	Limitation of motion ____	Numbness ____	Speech disturbance___
Joint trouble ____	Shaking ____	Difficulty walking ____	Muscle jerking ____
Paralysis ____	Personality change ____	Varicose vein(s) ____	Memory loss ____

FAMILY HISTORY

CIRCLE IF ANY BLOOD RELATIVE HAS OR HAD THE CONDITIONS LISTED BELOW. IF THE RELATIVE IS DECEASED, INCLUDE THE AGE AT THE TIME OF DEATH

Asthma _____	High Blood Pressure _____
Cancer or tumor _____	Sickle Cell Disease _____
Diabetes _____	Glaucoma _____
Stroke _____	Tuberculosis _____
Heart Disease _____	Thyroid _____
Osteoporosis _____	Lung Disease _____
Substance Abuse _____	Mental Health _____

For Women Only

When was your last menstrual period? _____
At what age did your menstrual periods start? _____
Describe any trouble you are having with your periods (i.e. excessive bleeding, pain) _____
How many times have you been pregnant? _____
Any abortions? ____ Any miscarriages? ____ Any C Sections?___
Do you self-examine your breasts regularly? _____
Has your mother, sister or aunt had Breast, Ovarian or Cervical (Uterine) cancer? _____
Have you been told your PAP smear was abnormal? _____

For Men Only

Do you have problems with urinating (i.e., starting, stopping problems, increased frequency, split stream)? _____

Do you have prostate problems? _____

Do you do a testicular self-exam? _____

Do you have erection problems? _____