OhioHealth

Primary Care & Pediatric Physicians

Health History Questionnaire

Patient Name: _____ **Date Form Completed:**_____

Birthdate:_____ **Occupation:** _____

Retired: Yes No If Yes, what line of work were you in?_____

Disables: Yes No If Yes, what age did you become disabled?____ **For what medical condition?**_____

Marital Status: Single Married Divorced Legally Separated Life Partner Widowed

Number of Children: _____ **Who lives at home with you:** _____

Previous PCP: _____ **Last Visit:** _____

1. **Chief Complaint(s):** In order of importance, please list the present health concerns, symptoms, or problems you are experiencing): _____

   _____

   _____

2. **Drug Allergies:**

Medication Name	Reaction

3. **Please list all medications you are currently taking.** If you run out of space, please continue list on another sheet. Be sure to include any vitamins or herbal supplements in your list.

Medication Name	Dosage (mg)	Times Per Day

4. **Alternative Therapies:**

☐ Herbs	☐ Acupuncture
☐ Homeopathic	☐ Chiropractic
☐ Vitamins	☐ Massage Therapy

5. **Past Medical History** Have you ever had any of the following? (Check all that apply):

☐ Alcoholism	☐ Myocardial Infarction (heart attack)
☐ Anemia	☐ Nerve/Muscle Disease
☐ Anxiety	☐ Osteoporosis
☐ Arthritis	☐ Psychiatric Disorder (If yes specify)
☐ Asthma	
☐ Cancer (if Yes, specify below) _____ _____	
☐ Cataracts	
☐ CHF	
☐ Clotting Disorder	☐ Pulmonary Embolism
☐ COPD	☐ Seizure
☐ Deep Vein Thrombosis (DVT)	☐ Sickle Cell Anemia
☐ Depression	☐ Stroke
☐ Diabetes	☐ Thyroid Disease
☐ Emphysema	☐ TIA (mini-stroke)
☐ Gerd	☐ Tuberculosis
☐ Glaucoma	☐ Ulcers of the stomach
☐ Heart Disease	☐ Any other conditions (Specify)
☐ Heart Murmur	
☐ Hepatitis	
☐ History of Blood Transfusion	
☐ HIV/AIDS	
☐ Hyperlipidemia (Cholesterol)	
☐ Hypertension (Blood Pressure)	
☐ Kidney Disease	
☐ Liver Disease	
☐ Lung Problems	
☐ Meningitis	

6. **Past Surgical History:**

Date	Surgical Procedure

7. **Last Time You Had A (list a year):**

	Year		Year
Flu Vaccine		**Tetanus Vaccine**	
Hepatitis B Vaccine		**TB (Tuberculosis) Test**	
Pneumonia Shot		**Eye Exam**	
Colonoscopy		**PSA (Prostate Blood Test) (Men Only)**	
Cholesterol Test		**Eye Exam**	
Mammogram			

8. **Family History:** ☐ I am adopted ☐ I do not know my family medical history

Family Member	**Alive**	**Deceased**	Alcohol abuse	Arthritis	Asthma	Birth defects	Cancer	COPD	Depression	Diabetes	Drug Abuse	Early death	Hearing loss	Heart disease	Hyperlipidemia	Hypertension	Kidney disease	Learning disabilities	Mental illness	Mental retardation	Miscarriages/ stillbirth	Stroke	Vision loss	Clotting disorder	Lung Disease	Tuberculosis
Mother																										
Father																										
Sister																										
Brother																										
Daughter																										
Son																										
Mat. Aunt																										
Uncle																										
Pat. Aunt																										
Uncle																										
Mat. Grandma																										
MGF																										
Pat. Grandma																										
PGF																										

Other significant family health problems not listed above (including Cancer Type):

_____

9. **Social History:**

Smoking Status:	☐ Packs per day ___ for ___ years ☐ Quit Smoking Y N When _____ ☐ Never
Alcohol	☐ Drinks per week _____
Caffeine	☐ Cups per day _____
Illegal Drugs	☐ Type
Exercise	☐ Times per week _____
Sexually Active	Y N ☐ Men ☐ Women ☐ Both

10. **FOR WOMEN ONLY:**

Age at onset of menstrual period:	Date of last menstrual period:
Use Birth Control? Y N	Type of Birth Control:
Number of Pregnancies:	Number of Live Births:
Number of Abortions:	Number of Miscarriages:
Year of Last:	
Breast Exam:	Results:_____
Mammogram:	Results:_____
Pap:	Results:_____

Patient Signature:_____ Date:_____