Adventist Health Partners
Keeping you well

Health History Questionnaire

Date: _____

Name: _____ Birthdate: _____

Has any information changed since your last visit?

☐ Yes (please describe below) ☐ No Reported height _____ Reported weight _____

Age _____ Hand Dominance ☐ Right ☐ Left

Who is your referring physician? _____

Address _____

Who is your primary care physician? _____

May we share information with your primary care doctor? ☐ Yes ☐ No

What is the reason for your visit today? (indicate left or right as appropriate) _____

_____

What date did you first experience the above referenced symptoms/injury (date of injury)? _____

Please describe any treatment you have received for these symptoms _____

_____

_____

PHARMACY INFORMATION

Name _____

Address _____ Phone _____

MEDICAL HISTORY

Please indicate if you have a problem with any of the following:

☐ Arthritis (*specify*) ☐ Diabetes ☐ High Blood Pressure ☐ Kidney Disease ☐ Stroke

_____ ☐ Cancer ☐ High Cholesterol ☐ Sleep Apnea ☐ Other (*specify*)

☐ Heart Disease ☐ HIV ☐ Hepatitis ☐ Stomach Ulcers _____

_____

Have you ever had any surgical procedure? ☐ Yes ☐ No

If yes, please describe _____

_____

_____

_____

Are you taking any medications? ☐ Yes ☐ No

Please list medications and dosages (include over the counter medications or provide a separate list) _____

_____

_____

Are you allergic or sensitive to:

☐ Penicillin ☐ Sulfa ☐ Tape/adhesives ☐ Betadine (*iodine*) ☐ Aspirin ☐ None

☐ Tylenol ☐ Ibuprofen ☐ Vicodin ☐ Codeine ☐ Latex ☐ Other (*specify*)

_____

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SOCIAL HISTORY

Occupation or grade in school _____

Do you smoke? ☐ Yes ☐ No If yes ☐ ½ ppd ☐ 1 ppd ☐ 1½ ppd ☐ 2 ppd

Did you smoke in the past? ☐ Yes ☐ No How many years did you smoke? _____ When did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No If yes ☐ Socially ☐ 1 dayly ☐ 2 daily ☐ >2 daily

Recreational drug use? ☐ Yes ☐ No Explain _____

Do you consume caffeine? ☐ Yes ☐ No How much _____ ☐ daily ☐ weekly ☐ monthly

FAMILY HISTORY

Is there any family history (*blood relative*) of
Please indicate all that apply

☐ Arthritis _____ Type _____ ☐ Diabetes _____ ☐ Other (*specify*)

☐ Cancer _____ ☐ Heart Disease _____ _____

☐ Circulatory Problems _____ ☐ Kidney Disease _____ _____

REVIEW OF SYSTEMS

Please indicate all that apply

☐ Bruise easily	☐ Diarrhea	☐ Joint pain/swelling	☐ Palpitations	☐ Sore throat
☐ Blurred vision	☐ Fatigue	☐ Leg swelling	☐ Problem urinating	☐ Stomach pain
☐ Chest pain	☐ Fever, chills	☐ Nausea/vomiting	☐ Rash/Itching	☐ Weakness
☐ Cough	☐ Headaches	☐ Nervousness	☐ Rectal bleeding	☐ Weight change
☐ Cramps	☐ Hearing loss	☐ Nose bleeds	☐ Shortness of breath	☐ Wheezing
☐ Depression	☐ Insomnia	☐ Numbness	☐ Skin ulcers	

WORKMAN'S COMPENSATION

Plan name _____ Date of injury _____

Address _____ Phone number _____

Status: ☐ Part time ☐ Full time

For physician's use Reviewed by _____ Date _____