www.bayareatotalhealth.com

Bay Area Total Health Medical Group, PA

Houston Physician's Hospital
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Today's Date: _____

HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First, M.I.):*		**DOB:**	**AGE:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			☐ M ☐ F
Address:		**City:**	**State:**
Zip:	**Home Phone:**	**Work Phone:**	**SSN:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio				
Immunizations and dates:	☐ Tetanus	☐ Pneumonia	☐ Influenza	☐ Tetanus
	☐ Hepatitis	☐ Chickenpox	☐ H1N1	☐ Other

List any medical problems that other doctors have diagnosed and physicians you are seeing

Have You Ever Had Any of the Following Surgeries

Surgery	**Year**	**Surgery**	**Year**		**Surgery**	**Year**	
☐ Tonsils		☐ Cataracts		☐ Right ☐ Left ☐ Bilateral	☐ Mastectomy		☐ Right ☐ Left ☐ Bilateral
☐ Adenoids		☐ Hernia		☐ Hiatal ☐ R. L. Inguinal	☐ Prostate		
☐ Appendix		☐ Hysterectomy		☐ Total ☐ Partial	☐ Back		Location:
☐ Thyroid		☐ Tubes & Ovaries		☐ Right ☐ Left ☐ Bilateral	☐ Bones, Joints		Specify:
☐ Hemorrhoids		☐ Gall Bladder		☐ For Stones	or Muscles		
☐ Other							

Other Hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name of the Drug	Strength	Frequency Taken
Allergies to Medications or Other Reactions		
Name the Drug or “Other”	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to “binge” drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ 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?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Physical and/or mental abuse has 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?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

		AGE	ALIVE	DECEASED	CAUSE OF DEATH			AGE	ALIVE	DECEASED	CAUSE OF DEATH
Father			☐ Y ☐ N	☐ Y ☐ N		**Children**	☐ M ☐ F		☐ Y ☐ N	☐ Y ☐ N	
Mother			☐ Y ☐ N	☐ Y ☐ N			☐ M ☐ F		☐ Y ☐ N	☐ Y ☐ N	
Sibling	☐ M ☐ F		☐ Y ☐ N	☐ Y ☐ N			☐ M ☐ F		☐ Y ☐ N	☐ Y ☐ N	
	☐ M ☐ F		☐ Y ☐ N	☐ Y ☐ N			☐ M ☐ F		☐ Y ☐ N	☐ Y ☐ N	
	☐ M ☐ F		☐ Y ☐ N	☐ Y ☐ N		**Grandmother** *Maternal*			☐ Y ☐ N	☐ Y ☐ N	
	☐ M ☐ F		☐ Y ☐ N	☐ Y ☐ N		**Grandfather** *Maternal*			☐ Y ☐ N	☐ Y ☐ N	
	☐ M ☐ F		☐ Y ☐ N	☐ Y ☐ N		**Grandmother** *Paternal*			☐ Y ☐ N	☐ Y ☐ N	
	☐ M ☐ F		☐ Y ☐ N	☐ Y ☐ N		**Grandfather** *Paternal*			☐ Y ☐ N	☐ Y ☐ N	

Have any of your blood relatives (parents, siblings, children or grandparents) ever had any of the following: If so, state who:

☐ Arthritis	☐ Thyroid Disease	☐ Hypertension
☐ Heart Disease	☐ Cancer	☐ Tuberculosis
☐ Glaucoma	☐ Asthma	☐ Stroke
☐ Diabetes	☐ Excessive Bleeding	☐ Other

MENTAL HEALTH

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

WOMEN ONLY

Age at onset of menstruation:	Date of last menstruation:				
Period every _____ days	Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No		
Number of pregnancies _____ Number of live births _____	Are you pregnant or breastfeeding?	☐ Yes	☐ No		
Ages of Children:	Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No		
Date of last pap exam?	Have you ever had other than Class I Pap Smears? Class: _____ Date:	☐ Yes	☐ No		
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?		☐ Yes	☐ No		
Any problems with control of urination? Any blood in your urine?		☐ Yes	☐ No		
Any urinary tract, bladder, or kidney infections within the last year?		☐ Yes	☐ No		
Any hot flashes or sweating at night? ☐ Yes ☐ No	Any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No		
Recurrent Vaginitis ☐ Yes ☐ No	Endometriosis ☐ Yes ☐ No	Ovarian Cysts ☐ Yes ☐ No	Ovarian Tumors	☐ Yes	☐ No
Currently on Birth Control Pills? If so, # of Years: _____ and Type: _____		☐ Yes	☐ No		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER ILLNESSES

Have you ever had any of the following illnesses (answer only if positive)?

☐ Anemia	☐ Diverticulitis	☐ Hiatal Hernia
☐ Arthritis Gout ☐ or Rheumatoid ☐	☐ Emphysema	☐ High Blood Pressure
☐ Bronchitis	☐ Epilepsy	☐ Liver Disease Type:
☐ Cancer Type:	☐ Excessive Bleeding	☐ Heart Attack
☐ Depression/Nervous Disorder	☐ Glacoma	☐ Migraine Headaches
☐ Diabetes	☐ Goiter	☐ Kidney Disease
☐ Phlebitis (Inflamed Veins)	☐ Sickle Cell Anemia	☐ Kidney Stones
☐ Stroke	☐ Prostatitis	☐ Angina
☐ Ulcers ☐ Peptic or ☐ Duodenal	☐ Coronary Heart Disease	☐ Other
☐ Muscles, Bones or Joint	Describe:	