



www.bayareatotalhealth.com

Bay Area Total Health Medical Group, PA

Houston Physician's Hospital
 333 N. Texas Avenue, Suite 4100
 Webster, TX 77598
 832.984.6549

Today's
Date:

HEALTH HISTORY QUESTIONNAIRE

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

Name <i>(Last, First, M.I.):</i>			DOB:		AGE:	
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> M <input type="checkbox"/> F						
Address:				City:		State:
Zip:	Home Phone:		Work Phone:		SSN:	

PERSONAL HEALTH HISTORY

Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio					
Immunizations and dates:	<input type="checkbox"/> Tetanus		<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Influenza	<input type="checkbox"/> Tetanus
	<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Chickenpox	<input type="checkbox"/> H1N1	<input type="checkbox"/> 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	
<input type="checkbox"/> Tonsils		<input type="checkbox"/> Cataracts		<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	<input type="checkbox"/> Mastectomy		<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
<input type="checkbox"/> Adenoids		<input type="checkbox"/> Hernia		<input type="checkbox"/> Hiatal <input type="checkbox"/> R. L. Inguinal	<input type="checkbox"/> Prostate		
<input type="checkbox"/> Appendix		<input type="checkbox"/> Hysterectomy		<input type="checkbox"/> Total <input type="checkbox"/> Partial	<input type="checkbox"/> Back		Location:
<input type="checkbox"/> Thyroid		<input type="checkbox"/> Tubes & Ovaries		<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	<input type="checkbox"/> Bones, Joints or Muscles		Specify:
<input type="checkbox"/> Hemorrhoids		<input type="checkbox"/> Gall Bladder		<input type="checkbox"/> For Stones			
<input type="checkbox"/> Other							

Other Hospitalizations

Year	Reason	Hospital

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

Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

		AGE	ALIVE	DECEASED	CAUSE OF DEATH			AGE	ALIVE	DECEASED	CAUSE OF DEATH
Father			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		Children	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	Mother		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
Sibling		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		Grandmother <i>Maternal</i>		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N			Grandfather <i>Maternal</i>		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		Grandmother <i>Paternal</i>		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		Grandfather <i>Paternal</i>		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		

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

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Asthma	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Other

MENTAL HEALTH

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

WOMEN ONLY

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

MEN ONLY

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

OTHER ILLNESSES

Have you ever had any of the following illnesses (answer only if positive)?			
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Hiatal Hernia	
<input type="checkbox"/> Arthritis	Gout <input type="checkbox"/> or Rheumatoid <input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver Disease	Type: _____
<input type="checkbox"/> Cancer	Type: _____	<input type="checkbox"/> Heart Attack	
<input type="checkbox"/> Depression/Nervous Disorder	<input type="checkbox"/> Glacoma	<input type="checkbox"/> Migraine Headaches	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Goiter	<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Phlebitis (Inflamed Veins)	<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Kidney Stones	
<input type="checkbox"/> Stroke	<input type="checkbox"/> Prostatitis	<input type="checkbox"/> Angina	
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Peptic or <input type="checkbox"/> Duodenal	<input type="checkbox"/> Other	
<input type="checkbox"/> Muscles, Bones or Joint	Describe: _____		