



Sanborn, Hartley, Boyden

**Clinic
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.)	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB:	Today's Date:
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Email Address:	
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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
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Occupation:	
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Primary Doctor (Provider):	Date of last physical exam:
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PRESENT HEALTH CONCERNS/SYMPTOMS

Today's symptoms – please check all that apply. (see attached)

Constitutional	Eyes	Gastrointestinal
<input type="checkbox"/> Fever	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Chills	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Nausea
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Eye Discharge	<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Weakness	<input type="checkbox"/> Eye Redness	<input type="checkbox"/> Diarrhea
Skin	Respiratory	Constipation
<input type="checkbox"/> Rash	<input type="checkbox"/> Cough	<input type="checkbox"/> Blood in Stool
<input type="checkbox"/> Itching	<input type="checkbox"/> Sputum Production	Musculoskeletal
Head/Eyes/Nose/Throat	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Headaches	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Back Pain
<input type="checkbox"/> Hearing Loss	Urinary	<input type="checkbox"/> Joint Pain
<input type="checkbox"/> Ear Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Falls
<input type="checkbox"/> Ear Discharge	<input type="checkbox"/> Urgency	Neurological
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Frequency	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Congestion	Heme/Allergy	<input type="checkbox"/> Tingling
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Environmental Allergies	<input type="checkbox"/> Tremor
Cardiovascular	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Sensory Change
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Bleed Easily/A lot	<input type="checkbox"/> Speech Change
<input type="checkbox"/> Palpitations		<input type="checkbox"/> Seizures
<input type="checkbox"/> Leg Swelling		

Are there any specific topics you'd like to discuss today?

PAST MEDICAL HISTORY

Past Medical Problems		Year Diagnosed
Past Surgeries		Date
List your prescribed medications and over-the-counter drugs		
Medication	Strength/dose	Frequency Taken
Allergies to medications		
Name the Drug	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 minutes)			
	<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"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low		
	Rank fat intake	<input type="checkbox"/> High <input type="checkbox"/> Medium <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		

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
	# of years _____ Or year quit _____			

FAMILY HEALTH HISTORY					
	Age	Significant Health Problems	Children	Age	Significant Health Problems
Father			<input type="checkbox"/> M <input type="checkbox"/> F		
			<input type="checkbox"/> M <input type="checkbox"/> F		
Mother			<input type="checkbox"/> M <input type="checkbox"/> F		
			<input type="checkbox"/> M <input type="checkbox"/> F		
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		

PATIENT HEALTH QUESTIONNAIRE				
Over the last 2 weeks, how often have you been bothered by any of the following problems? (circle answers)	Not at all	Several Days	More than ½ the days	Nearly every day
1. Little interest of pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or Watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Add columns 2,3 and 4				
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Some-what difficult	Very difficult	Extremely difficult