Doctors on Call
Est. 1968

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.): _____ ❑ M ❑ F DOB: _____

Marital status: ❑ Single ❑ Partnered ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Name of primary doctor: _____ Date of last physical exam: _____

Office Tel:_____ Fax: _____Email:_____

Name of specialist: _____

Office Tel:_____ Fax: _____Email:_____

PERSONAL HEALTH HISTORY

Childhood illness: ❑ Measles ❑ Mumps ❑ Rubella ❑ Chickenpox ❑ Rheumatic Fever ❑ Polio

Immunizations and dates:
❑ Tetanus ❑ Pneumonia
❑ Hepatitis ❑ Chickenpox
❑ Influenza ❑ MMR Measles, Mumps, Rubella

List any medical problems that other doctors have diagnosed:

1. _____
2. _____
3. _____
4. _____

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

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

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

***Add any additional medications to the last page**

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

- ❑ 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 day/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
	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
	Do you have an Advance Directive or Living Will?	❑ Yes ❑ No
	Would you like information on the preparation of these?	❑ Yes ❑ No
	Physical and/or mental abuse have 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

		DECEASED	SIGNIFICANT HEALTH PROBLEMS
Father		❑ Yes ❑ No	
Mother		❑ Yes ❑ No	
Sibling	❑ M ❑ F	❑ Yes ❑ No	
Sibling	❑ M ❑ F	❑ Yes ❑ No	
Sibling	❑ M ❑ F	❑ Yes ❑ No	
Sibling	❑ M ❑ F	❑ Yes ❑ No	
Sibling	❑ M ❑ F	❑ Yes ❑ No	
Sibling	❑ M ❑ F	❑ Yes ❑ No	

		DECEASED	SIGNIFICANT HEALTH PROBLEMS
Children	❑ M ❑ F	❑ Yes ❑ No	
	❑ M ❑ F	❑ Yes ❑ No	
	❑ M ❑ F	❑ Yes ❑ No	
	❑ M ❑ F	❑ Yes ❑ No	
Grandmother *Maternal*		❑ Yes ❑ No	
Grandfather *Maternal*		❑ Yes ❑ No	
Grandmother *Paternal*		❑ Yes ❑ No	
Grandmother *Paternal*		❑ Yes ❑ No	

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

*** Additional Medication or Comments:**