Needmore Road Primary Care

Premier Health
Premier Physician Network

Health History Questionnaire

Patient Name: _____

Date of Birth: _____ Today's Date: _____

Reason for Appointment: _____

Previous Family Doctor: _____ Date Last Seen: _____

Medical History	**Circle Yes or No**	
Diabetes	Yes	No
High Blood Pressure	Yes	No
Cancer	Yes	No
Stroke	Yes	No
Heart Trouble	Yes	No
Arthritis/Gout	Yes	No
Bleeding Problems	Yes	No
Glaucoma	Yes	No
Stomach Ulcers	Yes	No
Thyroid Trouble	Yes	No
Venereal Disease	Yes	No

Allergies: _____

_____

_____

_____

Female Patients: Menstrual History

Age at Onset _____ Cycle Length (days)_____

# of Pregnancies _____ Live Births _____

Miscarriages _____ Abortions _____

Age at Menopause _____

Date last Menstrual Period Began _____

Last Pap Smear _____ Last Mammo _____

_____

Family Medical History (Living or Deceased)

	Age	Diseases	Cause of death if known
Father			
Mother			
Brothers			
Sisters			
Spouse			
Children			

Past Medical History:

Previous Hospitalizations/Surgeries (Type of Surgery, Hospital Date):

_____

_____

_____

Medications – Please bring all bottles of current medication with you.

Social History:

Use of Alcohol: Never _____ Rarely _____ Moderate _____ Daily _____

Use of Tobacco: Never _____ Current Packs/Day _____ Year Started _____ Year Quit _____

Use of Illegal Drugs: Never _____ Type/Frequency_____

Employed _____ Retired _____ What kind of work _____

Hobbies/Interest _____

Other information you think might be helpful for us to provide you with the best medical care.

_____

_____

Please continue on back!

Review of Systems: **Are you currently experiencing any of the following? Please answer all questions**

CONSTITUTIONAL

Activity change ..... No Yes
Appetite change ..... No Yes
Chills ..... No Yes
Diaphoresis (excessive sweating) ..... No Yes
Fatigue ..... No Yes
Fever ..... No Yes
Recent weight change ..... No Yes

HENT

Neck pain ..... No Yes
Neck stiffness ..... No Yes
Ear discharge/drainage ..... No Yes
Hearing loss ..... No Yes
Ear pain ..... No Yes
Tinnitus (ringing in the ears) ..... No Yes
Nose bleeds ..... No Yes
Congestion ..... No Yes
Rhinorrhea (runny nose) ..... No Yes
Post nasal drip ..... No Yes
Sneezing ..... No Yes
Sinus pressure ..... No Yes
Dental problems ..... No Yes
Mouth sores ..... No Yes
Sore throat ..... No Yes
Trouble swallowing ..... No Yes
Voice change ..... No Yes

EYES

Eye discharge ..... No Yes
Eye itching ..... No Yes
Eye pain ..... No Yes
Eye redness ..... No Yes
Photophobia (abnormal sensitivity to light) ..... No Yes
Visual disturbance ..... No Yes

RESPIRATORY

Apnea (pauses in breathing) ..... No Yes
Chest tightness ..... No Yes
Choking ..... No Yes
Coughing ..... No Yes
Shortness of breath ..... No Yes
Stridor (high-pitched breathing sound) ..... No Yes
Wheezing ..... No Yes

CARDIOVASCULAR

Chest pains ..... No Yes
Leg swelling ..... No Yes
Palpitations (sudden heart beat changes) ..... No Yes

GASTROINTESTINAL

Abdominal distention ..... No Yes
Abdominal pain ..... No Yes
Anal bleeding ..... No Yes
Blood in stool ..... No Yes
Constipation ..... No Yes
Diarrhea ..... No Yes
Nausea ..... No Yes
Rectal pain ..... No Yes
Vomiting ..... No Yes

ENDOCRINE

Cold intolerance ..... No Yes
Heat intolerance ..... No Yes
Polydipsia (excessive thirst) ..... No Yes
Polyphagia (excessive hunger) ..... No Yes
Polyuria (excessive urination) ..... No Yes

GENITOURINARY

Difficulty urinating ..... No Yes
Dysuria (painful urination) ..... No Yes
Enuresis (night-time incontinence) ..... No Yes
Flank pain ..... No Yes
Frequent urination ..... No Yes
Genital sore ..... No Yes
Hematuria (blood in urine) ..... No Yes
Male - Penile discharge ..... No Yes
Male - Penile pain ..... No Yes
Male - Penile swelling ..... No Yes
Male - Scrotal swelling ..... No Yes
Male - Testicular pain ..... No Yes
Urgency ..... No Yes
Urine decreased ..... No Yes
Change of force of strain when urinating ..... No Yes
Incontinence or dribbling ..... No Yes
Sexual difficulty ..... No Yes
Female – pain with periods ..... No Yes
Female – irregular periods ..... No Yes
Female – vaginal discharge ..... No Yes

MUSCULOSKELETAL

Arthralgias (joint pain) ..... No Yes
Back pain ..... No Yes
Gait problems ..... No Yes
Joint swelling ..... No Yes
Myalgias (muscle pain) ..... No Yes

SKIN

Change in skin color ..... No Yes
Pallor (pale color of the skin) ..... No Yes
Rash ..... No Yes
Wound ..... No Yes

ALLERGIC/IMMUNOLOGIC

Environmental allergies ..... No Yes
Food allergies ..... No Yes
Immunocompromised ..... No Yes

NEUROLOGICAL

Dizziness ..... No Yes
Facial asymmetry ..... No Yes
Headaches ..... No Yes
Light headedness ..... No Yes
Numbness or tingling sensations ..... No Yes
Convulsions or seizures ..... No Yes
Speech difficulty ..... No Yes
Syncope ..... No Yes
Tremors ..... No Yes
Weakness ..... No Yes

HEMATOLOGIC/LYMPATIC

Adenopathy (abnormal lymph nodes) ..... No Yes
Easily bruise or bleed ..... No Yes

PSYCHIATRIC

Agitation ..... No Yes
Behavioral problems ..... No Yes
Confusion ..... No Yes
Decreased Concentration ..... No Yes
Dysphoric mood (Depression) ..... No Yes
Hallucinations ..... No Yes
Hyperactive ..... No Yes
Self-injury ..... No Yes
Sleep disturbance ..... No Yes
Suicidal ideas ..... No Yes
Anxiety ..... No Yes