Primary Care Services
MEDICAL HEALTH HISTORY QUESTIONNAIRE

PrimeHealth PRIMARY CARE

Name: _____ **DOB:** _____ **Date:** _____

Information provided on this form will assist your health care provider to better understand your medical conditions and concerns. All questions are optional and will be kept confidential.

Main reason for today's visit: _____
Other Concerns: _____

ALLERGIES

☐ **NO KNOWN ALLERGIES**

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1.	
2.	
3.	

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

IMMUNIZATION HISTORY

Immunizations and most recent date:

- ☐ Flu Shot Date: _____
- ☐ Tetanus/Diphtheria/Pertussis (DPT) Date: _____
- ☐ Chickenpox Date: _____
- ☐ Measles/Mumps/Rubella (MMR) Date: _____
- ☐ Human Papillomavirus (HPV) Date: _____
- ☐ Meningitis Vaccine Date: _____
- ☐ Shingles Date: _____
- ☐ Pneumonia Vaccine Date: _____
- ☐ Hepatitis A Date: _____
- ☐ Hepatitis B Date: _____
- ☐ Haemophilus Influenza Type B (Hib) Date: _____
- ☐ Td or Tdap Date: _____

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Age at First Menstrual Cycle _____
Age at First Childbirth _____
Current Birth Control _____
Date of Last Mammogram Date: _____
If Post-Menopausal, Age at Menopause _____
Hysterectomy ☐ Yes ☐ No
Breast Augmentation ☐ Yes ☐ No
Tubal Ligation ☐ Yes ☐ No
Breast Reduction ☐ Yes ☐ No
Date of Last Menstrual Cycle Date: _____
Date of Last Pap Smear Date: _____ ☐ normal ☐ abnormal
Location: _____ ☐ normal ☐ abnormal
Post-Menopausal bleeding ☐ yes ☐ no
Cesarean Section ☐ Yes ☐ No
Mastectomy ☐ Yes ☐ No

MEN AND WOMEN

Date of Last Colonoscopy Date: _____ Location: _____ ☐ normal ☐ abnormal

PAST MEDICAL HISTORY

Please check all that apply:

☐ Abnormal Vaginal Bleeding
☐ Acid Reflux (GERD)
☐ Anemia
☐ Asthma
☐ Back Pain
☐ Bladder or Kidney Problems
☐ Cancer
☐ Congestive Heart Failure (CHF)
☐ COPD
☐ Difficulty Sleeping
☐ Dizziness
☐ Dementia/Alzheimers
☐ Depression/Anxiety
☐ Diabetes
☐ DVT/Blood Clot
☐ Epilepsy/Seizures
☐ Headaches/Migraines
☐ Heart Problems
☐ High Blood Pressure (HTN)
☐ High Cholesterol
☐ Kidney Stones
☐ Parkinson's Disease
☐ Recurrent Urinary Tract Infection (UTI)
☐ Sleep Apnea
☐ Thyroid Disease
☐ TIA/Stroke
☐ Other: _____
☐ Other: _____

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL

SOCIAL HISTORY

Marital Status

☐ Married ☐ Single
☐ Separated ☐ Divorced
☐ Widowed ☐ Domestic Partner

Exercise Level

☐ None (No exercise)
☐ Occasional exercise
☐ Moderate exercise
☐ High level exercise

Tobacco Use

If not currently, did you ever use tobacco? ____ pks/day
☐ Cigarettes ____ per day
☐ Chew ____ per day
☐ Cigars ____ per day
☐ # of years ____ or year quit _____

Alcohol Use

Do you drink alcohol? ☐ Yes ☐ No
If yes, how often?
Daily ☐ Yes ☐ No
Socially Only ☐ Yes ☐ No
Occasionally ☐ < 3 times a week ☐ > 3 times a week

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	____	☐ Alcohol abuse ☐ Alzheimer's Disease ☐ Arthritis ☐ Asthma ☐ Autism ☐ Cancer ☐ COPD ☐ Depression ☐ Diabetes ☐ Disorder of Thyroid Gland ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Obesity ☐ Osteoporosis ☐ Stroke
Grandfather (maternal)	Y/N	____	☐ Alcohol abuse ☐ Alzheimer's Disease ☐ Arthritis ☐ Asthma ☐ Autism ☐ Cancer ☐ COPD ☐ Depression ☐ Diabetes ☐ Disorder of Thyroid Gland ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Obesity ☐ Osteoporosis ☐ Stroke
Grandmother (paternal)	Y/N	____	☐ Alcohol abuse ☐ Alzheimer's Disease ☐ Arthritis ☐ Asthma ☐ Autism ☐ Cancer ☐ COPD ☐ Depression ☐ Diabetes ☐ Disorder of Thyroid Gland ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Obesity ☐ Osteoporosis ☐ Stroke
Grandmother (paternal)	Y/N	____	☐ Alcohol abuse ☐ Alzheimer's Disease ☐ Arthritis ☐ Asthma ☐ Autism ☐ Cancer ☐ COPD ☐ Depression ☐ Diabetes ☐ Disorder of Thyroid Gland ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Obesity ☐ Osteoporosis ☐ Stroke
Father	Y/N	____	☐ Alcohol abuse ☐ Alzheimer's Disease ☐ Arthritis ☐ Asthma ☐ Autism ☐ Cancer ☐ COPD ☐ Depression ☐ Diabetes ☐ Disorder of Thyroid Gland ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Obesity ☐ Osteoporosis ☐ Stroke
Mother	Y/N	____	☐ Alcohol abuse ☐ Alzheimer's Disease ☐ Arthritis ☐ Asthma ☐ Autism ☐ Cancer ☐ COPD ☐ Depression ☐ Diabetes ☐ Disorder of Thyroid Gland ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Obesity ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	____	☐ Alcohol abuse ☐ Alzheimer's Disease ☐ Arthritis ☐ Asthma ☐ Autism ☐ Cancer ☐ COPD ☐ Depression ☐ Diabetes ☐ Disorder of Thyroid Gland ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Obesity ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	____	☐ Alcohol abuse ☐ Alzheimer's Disease ☐ Arthritis ☐ Asthma ☐ Autism ☐ Cancer ☐ COPD ☐ Depression ☐ Diabetes ☐ Disorder of Thyroid Gland ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Obesity ☐ Osteoporosis ☐ Stroke

PREVIOUS PRIMARY CARE PROVIDER

Name of Provider: _____ Phone: _____

Address: _____ Fax: _____

_____

_____

PHARMACY

Pharmacy Name: _____ Phone: _____

Address: _____ Fax: _____

_____

_____

_____ _____

Parent, Guardian, or Caregiver Signature Date

_____ _____

Patient Signature Date