

EverCare Medical Associates

HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit:

Other concerns:

ALLERGIES

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

ALLERGY

REACTION

- | | |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |

FAVORITE PHARMACY

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:

Chickenpox	Date: _____	Meningococcus	Date: _____
Flu Shot	Date: _____	MMR (<i>Measles, Mumps, Rubella</i>)	Date: _____
Gardasil/HPV	Date: _____	Pneumonia	Date: _____
Hepatitis A	Date: _____	Tdap (<i>Tetanus and pertussis</i>)	Date: _____
Hepatitis B	Date: _____	Tetanus	Date: _____
		Zostavax (<i>Shingles</i>)	Date: _____

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(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ Abnormal
 Last Mammogram Date _____ Abnormal
 Age of first menstrual period: _____
 Date of last menstrual period or age of menopause: _____
 Number of pregnancies: _____ births: _____
 miscarriages: _____ abortions: _____
 Cesarean sections If yes, then number: _____

Bleeding between periods
 Heavy periods
 Extreme menstrual pain
 Vaginal itching, burning, or discharge
 Wake in the night to go to the bathroom
 Hot flashes
 Breast lump or nipple discharge
 Painful intercourse
 Sexually active
 Current sexual partner is Female Male
 Do you use condoms Yes No
 Other Birth control method
 used: _____
 Interested in being screened for STD's

PAST MEDICAL HISTORY

Please check all that apply:

Anxiety Disorder	Diverticulitis	Kidney Disease
Arthritis	Fibromyalgia	Kidney Stones
Asthma	Gout	Leg/Foot Ulcers
Bleeding Disorder	Has Pacemaker	Liver Disease
Blood Clots (or DVT)	Heart Attack	Osteoporosis
Cancer	Heart Murmur	Polio
Coronary Artery Disease	Hiatal Hernia or Reflux Disease	Pulmonary Embolism
Claustrophobic	HIV or AIDS	Reflux or Ulcers
Diabetes - Insulin	High Cholesterol	Stroke
Diabetes - Non-Insulin	High Blood Pressure	Tuberculosis
Dialysis	Overactive Thyroid	Other

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1. _____	_____	_____	_____
1. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

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FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS					
Grandmother (maternal)	Y/N	_____	Alcoholism disease	Arthritis	Depression	Cancer	Diabetes	Genetic
			Heart disease	Hypertension	Osteoporosis	Stroke		
Grandfather (maternal)	Y/N	_____	Alcoholism disease	Arthritis	Depression	Cancer	Diabetes	Genetic
			Heart disease	Hypertension	Osteoporosis	Stroke		
Grandmother (paternal)	Y/N	_____	Alcoholism disease	Arthritis	Depression	Cancer	Diabetes	Genetic
			Heart disease	Hypertension	Osteoporosis	Stroke		
Grandfather (paternal)	Y/N	_____	Alcoholism disease	Arthritis	Depression	Cancer	Diabetes	Genetic
			Heart disease	Hypertension	Osteoporosis	Stroke		
Father	Y/N	_____	Alcoholism disease	Arthritis	Depression	Cancer	Diabetes	Genetic
			Heart disease	Hypertension	Osteoporosis	Stroke		
Mother	Y/N	_____	Alcoholism disease	Arthritis	Depression	Cancer	Diabetes	Genetic
			Heart disease	Hypertension	Osteoporosis	Stroke		
Brother/Sister	Y/N	_____	Alcoholism disease	Arthritis	Depression	Cancer	Diabetes	Genetic
			Heart disease	Hypertension	Osteoporosis	Stroke		
Brother/Sister	Y/N	_____	Alcoholism disease	Arthritis	Depression	Cancer	Diabetes	Genetic
			Heart disease	Hypertension	Osteoporosis	Stroke		
Other: _____	Y/N	_____	Alcoholism disease	Arthritis	Depression	Cancer	Diabetes	Genetic
			Heart disease	Hypertension	Osteoporosis	Stroke		

SOCIAL HISTORY

<p>Education Less than 8th grade High school 2 year college 4 year college Post graduate</p> <p>Marital Status Married Single Divorced Separated Widowed Domestic partner</p> <p>Exercise Level None (No exercise) Occasional exercise Moderate exercise High level exercise</p>	<p>Caffeine None Occasional Moderate Heavy # of cups/cans per day? _____</p> <p>Alcohol Do you drink alcohol? Yes No If so, how often? Occasionally < 3 times a week > 3 times a week</p> <p>How many drinks per week? ____</p> <p>Tobacco Do you use tobacco? Yes No</p>	<p>If not currently, did you ever use tobacco? Yes No Cigarettes - ____pks./day Chew - ____/day Cigars - ____/day # of years ____ Or year quit _____</p> <p>Drugs Do you currently use recreational or street drugs? Yes No If yes, list: _____ _____</p>
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REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic

Frequent Sneezing
Hives
Itching
Runny Nose
Sinus Pressure

Cardiovascular

Arm Pain on Exertion
Chest Pain on Exertion
Chest Heaviness/Pressure on Exertion
Irregular Heart Beats (Palpitations)
Known Heart Murmur
Light-headed on Standing
Shortness of Breath When Lying Down
Shortness of Breath When Walking
Swelling (edema)

Constitutional

Exercise Intolerance
Fatigue
Fever
Weight Gain (____lbs)
Weight Loss (____lbs)

Eyes

Dry Eyes
Irritation
Vision Change

Date of Last Exam: _____

Ears/Nose/Mouth/Throat

Bleeding Gums
Difficulty Hearing
Dizziness
Dry Mouth
Ear Pain
Frequent Infections
Frequent Nosebleeds
Hoarseness
Mouth Breathing
Mouth Ulcers
Nose/Sinus Problems
Ringing in Ears

Endocrine

Fatigue
Increased Thirst/Hunger/Urination

Gastrointestinal

Abdominal Pain
Black or Tarry Stool
Blood in Stool
Change in Appetite
Frequent Indigestion
Hemorrhoids
Trouble Swallowing
Vomiting
Vomiting Blood

Genitourinary

Blood in Urine
Difficulty Urinating
Incomplete Emptying
Increased Urinary Frequency
Urinary Loss of Control

Hematologic/Lymphatic

Easy Bruising/Bleeding
Swollen Glands

Integumentary (Skin)

Changes in Moles
Dry Skin
Eczema
Growth/Lesions
Itching
Jaundice (Yellow Skin/Eyes)
Rash

Musculoskeletal

Back Pain
Joint Pain
Muscle Aches
Muscle Weakness

Neurological

Dizziness
Fainting
Headaches
Memory Loss
Migraines
Numbness
Restless Legs
Seizures
Weakness

Psychiatric

Alcohol Overuse
Anxiety/Stress
Depression
Do Not Feel Safe in Relationship
Mania
Sleep Problems

Respiratory

Cough
Coughing Up Blood
Shortness of Breath
Sleep Apnea
Snoring
Wheezing

Please add any other information about your health that you would like your provider to know here:

Parent, Guardian, or Caregiver Signature

Date