Date:_____

Medical History Questionnaire

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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		
Previous or referring doctor:		**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and Dates:	☐ COVID-19	☐ Pneumonia
	☐ Tetanus	☐ Influenza
	☐ Hepatitis	☐ Chickenpox
	☐ MMR *Measles, Mumps, Rubella*	☐ Other _____

List any medical problems that other medical practitioners have diagnosed

List any Specialists/Other doctors that are currently treating you

Name of Doctor	Specialty	Name of Doctor	Specialty
1.		4.	
2.		5.	
3.		6.	

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

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

Please turn to next page

Preferred Pharmacy	
Name of Pharmacy	Address

List your prescribed drugs and over-the-counter treatments, such as vitamins and inhalers		
Name of Drug	Strength	Frequency Taken

Allergies to medications		
Name the Drug	Reaction To Drug	Reaction currently Active of Inactive
		☐ Active ☐ Inactive
		☐ Active ☐ Inactive
		☐ Active ☐ Inactive

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 sugar intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Soft Drinks/Caffeinated Beverages/Energy Drinks		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per 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
	If yes, are you attempting to get pregnant?				☐ Yes	☐ No
	If not planning to get pregnant, list contraceptive or barrier method you are using:					
	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 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 these issues with your provider?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

	Check One	Current Age or Age Deceased	Health History (i.e. diabetes, heart disease, any other health concerns) **if deceased, what was the cause of death
Father	☐ Living ☐ Deceased		
Paternal Grandfather	☐ Living ☐ Deceased		
Paternal Grandmother	☐ Living ☐ Deceased		
Mother	☐ Living ☐ Deceased		
Maternal Grandfather	☐ Living ☐ Deceased		
Maternal Grandmother	☐ Living ☐ Deceased		
Brother 1	☐ Living ☐ Deceased		
Brother 2	☐ Living ☐ Deceased		
Brother 3	☐ Living ☐ Deceased		
Sister 1	☐ Living ☐ Deceased		
Sister 2	☐ Living ☐ Deceased		
Sister 3	☐ Living ☐ Deceased		
Child 1	☐ Living ☐ Deceased		
Child 2	☐ Living ☐ Deceased		
Child 3	☐ Living ☐ Deceased		

Preferred Laboratory (*select one*)	
☐ Clinical Labs of Hawaii (CLH)	☐ Diagnostic Laboratory Services (DLS)

WOMEN ONLY

Age at onset of menstruation (i.e. your "period"):		
Date of last menstruation:		
Period every _____ days		
Do you have heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?		

CHECKLIST

Please place a check next to any symptoms/conditions that applies to you

☐ Pain	☐ Dry Skin	☐ Fatigue/Tiredness/Weakness
☐ Cold Feet/Hand	☐ Insomnia	☐ Feeling Cold, Dressing Warmly
☐ Weight Gain	☐ Constipation	☐ Dizziness/Vertigo
☐ Brittle Nails	☐ Soft/Ridge Nails	☐ Curved/Ingrown Big Toenails
☐ Hypertension	☐ Swelling of Hands/Fingers	☐ Swollen Upper Eyelids
☐ Hair Loss - Head	☐ Hair Loss at Armpits	☐ Hair Loss-Outside Edge of Eyebrows
☐ Hair Loss - Forearm	☐ Tingling/Numbness	☐ TMJ - Teeth Clenching
☐ Menstrual Problems	☐ Infertility	☐ Hysterectomy
☐ Depression	☐ Anxiety/Tension	☐ Lack of Perspiration
☐ Headaches	☐ Migraines	☐ Skin Rashes
☐ Acne	☐ Allergies	☐ Irregular Heart Rate
☐ Palpitation	☐ Heart Failure	☐ Atrial Fibrillation
☐ Diabetes	☐ Rheumatoid Arthritis	☐ Lupus
☐ Ear Ringing (Tinnitus)	☐ Ovarian Cyst	☐ Frequent Colds and Infections
☐ Anemia	☐ Deep Hoarse Voice	☐ Fibrocystic Breast
☐ Skin Moles	☐ Skin Cancers	☐ Brain Fog/Slow Memory

Does anyone in your family have Hypothyroidsm? _____

Is your Body Temperature less than 98°F? ☐ YES ☐ NO

What is your Average Body Temperature? _____