

**Family Physicians of Kendall, LLC**  
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**11160 SW 88<sup>TH</sup> St, Suites 104 & 105**  
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<b>Original Date:</b>	
<b>Dates Revised:</b>	

## HEALTH HISTORY QUESTIONNAIRE

All information provided in this questionnaire is strictly confidential and will not be released under any circumstances without your approval or a Court Order.

Name <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Relationship status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered (Male or Female)			
Previous or referring doctor:		Tel:	Date of last physical exam:
Primary language spoken:			

### PERSONAL HEALTH HISTORY

Past illnesses: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio <input type="checkbox"/> Meningitis <input type="checkbox"/> Other			
Immunizations and dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Human Papilloma Virus
	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Shingles
	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Polio	
	<input type="checkbox"/> Influenza	<input type="checkbox"/> Meningitis	
	<input type="checkbox"/> HIB/Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>	

List any medical problems that you have now or have had in the past	
Date	

Surgeries		
Date	Reason	Hospital

Other Hospitalizations		
Year	Reason	Hospital

<b>Have you ever had a blood transfusion?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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**List your prescribed medications and over-the-counter drugs, including vitamins, herbs, and supplements**

Name the Drug	Strength	Frequency Taken

**Allergies to medications**

Name the Drug	Reaction You Had

**HEALTH HABITS AND PERSONAL SAFETY**

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)			
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
<b>Diet</b>	Are you dieting?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?			
	Rank salt intake	<input type="checkbox"/> High	<input type="checkbox"/> Medium	<input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> High	<input type="checkbox"/> Medium	<input type="checkbox"/> Low
<b>Energy Drinks</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type and amount per day		
<b>Weight Loss supplements</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type and amount per day		
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Caffeinated drinks
	Number of cups/cans per day?			
<b>Alcohol</b>	Do you drink alcohol?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you drink?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Tobacco</b>	Do you use tobacco?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew – Amt./day	<input type="checkbox"/> Pipe – Amt./day	<input type="checkbox"/> Cigars – Amt./day
	<input type="checkbox"/> Number of years	<input type="checkbox"/> Or quit date		

<b>Drugs</b>	Do you currently use recreational or street drugs? Type?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Sex</b>	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Sexual Preference</b>	Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/>		
<b>Personal Safety</b>	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**FAMILY HEALTH HISTORY**

	AGE OR AGE AT DEATH	ALIVE(A)/ DEAD(D)	SIGNIFICANT HEALTH PROBLEMS OR CAUSE OF DEATH
<b>Father</b>			
<b>Mother</b>			
<b>Siblings</b>	<input type="checkbox"/> M	<input type="checkbox"/> A	
	<input type="checkbox"/> F	<input type="checkbox"/> D	
	<input type="checkbox"/> M	<input type="checkbox"/> A	
	<input type="checkbox"/> F	<input type="checkbox"/> D	
	<input type="checkbox"/> M	<input type="checkbox"/> A	
	<input type="checkbox"/> F	<input type="checkbox"/> D	
	<input type="checkbox"/> M	<input type="checkbox"/> A	
	<input type="checkbox"/> F	<input type="checkbox"/> D	
<b>Children</b>	<input type="checkbox"/> M	<input type="checkbox"/> A	
	<input type="checkbox"/> F	<input type="checkbox"/> D	
	<input type="checkbox"/> M	<input type="checkbox"/> A	
	<input type="checkbox"/> F	<input type="checkbox"/> D	
<b>Grandmother</b> <i>Maternal</i>	<input type="checkbox"/> M	<input type="checkbox"/> A	
	<input type="checkbox"/> F	<input type="checkbox"/> D	
		<input type="checkbox"/> A	
		<input type="checkbox"/> D	
<b>Grandfather</b> <i>Maternal</i>		<input type="checkbox"/> A	
		<input type="checkbox"/> D	
<b>Grandmother</b> <i>Paternal</i>		<input type="checkbox"/> A	
		<input type="checkbox"/> D	
<b>Grandfather</b> <i>Paternal</i>		<input type="checkbox"/> A	
		<input type="checkbox"/> D	

## MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How often or for how long do you feel sad, down or disinterested?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____ Miscarriages ____ Abortions ____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a Dilatation & Curettage, Hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		

## MEN ONLY

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

**SPECIAL TESTS**

Tests	Date	Normal	Details of Results or Treatment if any
PAP Smear		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mammogram		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Colonoscopy		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bone Density		<input type="checkbox"/> Yes <input type="checkbox"/> No	
PSA (prostate)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Biopsies		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other		<input type="checkbox"/> Yes <input type="checkbox"/> No	

**OTHER PROBLEMS**

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Eye/Vision
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight change
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level/Mood
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Hair/Nails
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	<input type="checkbox"/> Joints
<input type="checkbox"/> Bones	<input type="checkbox"/> Muscles	<input type="checkbox"/> Other pain/discomfort:

**ADDITIONAL INFO**

*Please add here additional information on any of the above, or any additional relevant information.*

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Patient's Signature