Portsmouth Internal Medicine Associates
HEALTH HISTORY QUESTIONNAIRE

Date _____ Name_____ DOB_____

Please enter the last date you had the following:

Physical examination: _____

Colonoscopy: _____

Pelvic exam/Pap: _____

Mammogram: _____

Bone density exam: _____

Tetanus vaccine: _____

Pneumococcal (pneumonia) vaccine: _____

Zoster (shingles) vaccine: _____

Measles/Mumps/Rubella: _____

Hepatitis B vaccine: _____

Influenza vaccine: _____

PPD (TB test): _____

Please check any of the following medical problems that you currently have or have had:

☐ Rheumatic Fever
☐ TB
☐ Hepatitis
☐ HIV/AIDS
☐ Diabetes
☐ Cancer or Tumor
☐ Colon polyp/tumor
☐ Blood Clots
☐ Breathing Problems
☐ Heart murmur
☐ High blood pressure
☐ High cholesterol
☐ Sexually transmitted diseases
☐ Lyme disease

Do you have any of the following:

☐ Abn. Weight Change
☐ Excessive Fatigue
☐ Fevers / Chills / Sweats
☐ Problems Sleeping

☐ Visual Problems
☐ Glasses/ Contacts
☐ Hearing Loss
☐ Ringing in Ears
☐ Sinus Infections
☐ Recurrent Mouth Sores

☐ Chest Pain
☐ Shortness of Breath

☐ Frequent Bronchitis
☐ Asthma / Wheezing
☐ Emphysema or COPD

☐ Heart Failure
☐ Irregular Heartbeat
☐ Other Heart Issues

☐ Abdominal Pain
☐ Heartburn or Regurgitation
☐ Change in Bowels
☐ Constipation or Diarrhea
☐ Blood in Stool
☐ Black Stool

☐ Kidney Problems
☐ Bladder Infections
☐ Urinary Discomfort
☐ Blood in Urine
☐ Urinary Incontinence
☐ Prostate Problems
☐ Sexual Difficulties

☐ Joint or Muscle Pain
☐ Skin Rashes
☐ Skin Lesions that Concern You
☐ Anemia
☐ Allergies

☐ Headaches
☐ Stroke
☐ Seizure
☐ Numbness / Tingling
☐ Weakness
☐ Memory loss

☐ Mental / Emotional Problems
☐ Depression
☐ Anxiety / Panic
☐ Suicide Attempt
☐ Sexually Abused
☐ Physically Abused

Females:

Age periods started: _____ Last period: _____

Number of pregnancies:_____ Number of live births: _____ Miscarriages: _____

Your age at the time of your 1st pregnancy _____

☐ Abnormal Mammogram ☐ Breast Lump ☐ Abnormal Pap smear

Please describe your use of the following:

☐ Currently smoke ☐ Never smoked ☐ Smoked in past, but not currently:

How much do you smoke?_____

How many years have you smoked? _____

How much did you smoke? _____

How many years did you smoke?_____

When did you stop smoking? _____

How many alcoholic beverages do you drink during an average week? _____

☐ Significant exposure to any toxic chemicals, fumes, radiation, asbestos? _____

Name _____ DOB_____

Family Medical History:

List the known medical problems your family members have had. If deceased, note approximately how old they were: (Specifically note heart disease, cancers, diabetes, elevated cholesterol, osteoporosis, autoimmune diseases, psychiatric illnesses).

Father's father: _____ Mother's father: _____

Father's mother:_____ Mother's mother: _____

Father:_____ Mother: _____

Brother(s): Sister(s):

Son(s): Daughter(s):

List ***all*** surgeries, medical problems, and major injuries (broken bones, motor vehicle accidents, and so on) you have had (if not indicated on previous page):

List ***all*** medications that you cannot take, and what sort of reaction you had to them:

List ***all*** medications, vitamins, and supplements you are currently taking:

List ***all*** health care providers you have seen in the past or are currently seeing:

_____ _____

Patient Signature Doctor Reviewed