Baptist Community Health Services, Inc.

Health History Questionnaire

Date _____ Name _____ DOB_____

Please answer every question on both sides of the following pages.

Please circle Y for "yes" or N for "no"

Y N Abnormal Weight Loss
Y N Abnormal Weight Gain
Y N Excessive Fatigue
Y N Insomnia
Y N Anemia
Y N Cancer or Tumor

Y N Glasses/Contacts
Y N Glaucoma
Y N Cataracts
Y N Other problems with vision

Y N Hearing Loss
Y N Ear Problems
Y N Ringing in Ears

Y N Allergies
Y N Frequent Sinus Infections

Y N Angina
Y N Frequent Chest Pain
Y N Irregular Heartbeat
Y N Heart Murmur

Y N High Cholesterol
Y N Heart Failure
Y N Heart Attack
Y N High Blood Pressure

Y N Breathing Problems
Y N Frequent Bronchitis
Y N Emphysema/COPD
Y N Pneumonia
Y N Asthma

Y N Heartburn/ Reflux
Y N Ulcer Disease
Y N Gallbladder Disease
Y N Blood in Stool
Y N Hepatitis
Y N Diarrhea, Constipation, or other changes in bowel habits

Y N Hemorrhoids
Y N Abdominal Pain
Y N Colon Polyp

Y N Urinary Frequency
Y N Bladder Infections
Y N Prostate Problems
Y N Urinary Incontinence
Y N Kidney Problems

Y N Broken Bones

Y N Rashes
Y N Hives
Y N Moles

Y N Seizure
Y N TIA
Y N Stroke
Y N Numbness
Y N Weakness
Y N Memory Loss
Y N Headaches

Y N Depression
Y N Anxiety/Panic Attacks
Y N Suicide Attempt
Y N Physical Abuse
Y N Sexual Abuse
Y N Mental Illness

Y N Diabetes
Y N Thyroid Disease
Y N Sexually Transmitted Diseases

Y N Breast Lump
____# Pregnancies
____# Live Births
____# Miscarriages
____# Abortions

Have you been exposed to or do you have a close family member with…
Y N HIV/AIDS
Y N Hepatitis
Y N TB (Tuberculosis)

☐ In the past 6 months, have you had any significant stressors or life changes?

_____
_____
_____
_____

Other medical problems:
☐ _____

List all medications, and vitamins you are taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List ***all*** surgeries you have had:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List ***all*** medication allergies:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

When did you last have any the following? (Please indicate month, year and location):

Colonoscopy	Date:_____	Never ☐
Bone Density/DEXA scan	Date:_____	Never ☐
Mammogram	Date:_____	Never ☐
Pap Smear	Date:_____	Never ☐

Please describe your use of tobacco products.

☐ None ☐ Cigarettes ☐ Smokeless Tobacco ☐ Pipe ☐ Cigars

How much do you or did you smoke _____ per day? For how many years _____ ?

Do you wish to quit? ☐ Now ☐ Soon ☐ Eventually ☐ Never

Have you quit? _____ When? _____

Alcohol: How often do you drink?

1. Never ☐
2. Occasionally (Social) ☐ If so, how much? _____
3. Daily ☐ If so, how much? _____

Please check if there is a history of any of the following diseases in your family.

☐ Heart Disease/Heart Attack ☐ Diabetes ☐ High Cholesterol ☐ Osteoporosis

☐ Colon Cancer ☐ Prostate Cancer ☐ Breast Cancer ☐ Ovarian Cancer ☐ Skin Cancer

Please list any additional medical conditions in your family _____

Patient Signature _____ Date _____

Staff Signature _____ Date _____