Desert Peaks Health Care
Health History Questionnaire

Patient Name (printed):____ Date of Birth:__________________________
Reason for Visit: ____

Past Medical History: (check all that apply)

☐Anxiety	☐Asthma	☐Colon polyps	☐Stroke
☐Depression	☐COPD/emphysema	☐Diverticulosis/Diverticulitis	☐Memory Loss/Dementia
☐Bipolar Disorder	☐Sleep Apnea	☐Stomach Ulcers	☐Parkinson's Disease
☐Insomnia	☐Heart Failure	☐GI Bleeding	☐Seizure Disorder
☐Anemia	☐Coronary Artery Disease	☐Crohn's Disease	☐Migraine Headache
☐Bleeding Disorder	☐Heart Attack	☐Ulcerative Colitis	☐Restless Leg Syndrome
☐Blood Clots (PE or DVT)	☐Atrial Fibrillation	☐Autoimmune Disorder	☐Kidney Disease
☐Eczema	☐Pacemaker	☐Chronic Back Pain	☐Kidney Stones
☐Psoriasis	☐High Blood Pressure	☐Osteoarthritis	☐Tuberculosis
☐Seasonal Allergies	☐High Cholesterol	☐Rheumatoid Arthritis	☐Hepatitis
☐Cancer – specify type	☐Heart Murmur	☐Gout	☐HIV/AIDS
_________________________	☐Leg/Foot Ulcers	☐Overactive Thyroid	☐Glaucoma
	☐Diabetes	☐Underactive Thyroid	☐Macular Degeneration

Gynecological History:
Last Menstrual Period: __________ # of Pregnancies: _____ # of Births: _____ # of C-sections: _____
History of hormone replacement therapy (dates): ____

Past Surgical History: ☐ Not applicable

Surgery	Reason	Date/Location
1.		
2.		
3.		
4.		
5.		
6.		

Medications: (list all prescription and over the counter medication, supplements, CPAP and oxygen) ☐ Not applicable

Medication	Strength/Dose	Frequency Taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Medication Allergies: ☐ Not applicable

Medication	Reaction
1.	
2.	
3.	
4.	
5.	

Health Maintenance:

☐Colonoscopy	Date: _____________	Provider/Location:____
☐Eye Examination	Date: _____________	Provider/Location:____
☐Bone Density	Date: _____________	Provider/Location:____
☐Mammogram	Date: _____________	Provider/Location:____
☐Pap Smear	Date: _____________	Provider/Location:____

Immunizations:

Vaccine	Date	Vaccine	Date
☐Gardasil/HPV #1	Date: ______________	☐MMR (measles, mumps, rubella)	Date: _____________
☐Gardasil/HPV #2	Date: ______________	☐Pneumonia/Prevnar-13	Date: _____________
☐Gardasil/HPV #3	Date: ______________	☐Pneumonia/Pneumovax	Date: _____________
☐Hepatitis A #1	Date: ______________	☐Tdap (tetanus with whooping cough)	Date: _____________
☐Hepatitis A #2	Date: ______________	☐Tetanus	Date: _____________
☐Hepatitis B #1	Date: ______________	☐Flu Shot	Date: _____________
☐Hepatitis B #2	Date: ______________	☐Shingles/Zostavax	Date: _____________
☐Hepatitis B #3	Date: ______________	☐Shingles/Shingrix #1	Date: _____________
☐Meningococcus	Date: ______________	☐Shingles/Shingrix #2	Date: _____________

Family History:

Relation	Alive	Age	Significant Health Problems		
Father	Y/N	____	☐Depression ☐Genetic Disease ☐Heart Attack ☐Stroke	☐Autoimmune Disease ☐High Blood Pressure ☐Glaucoma ☐Other: ___________________	☐Cancer ☐Diabetes ☐Osteoporosis
Mother	Y/N	____	☐Depression ☐Genetic Disease ☐Heart Attack ☐Stroke	☐Autoimmune Disease ☐High Blood Pressure ☐Glaucoma ☐Other: ___________________	☐Cancer ☐Diabetes ☐Osteoporosis
Sibling	Y/N	____	☐Depression ☐Genetic Disease ☐Heart Attack ☐Stroke	☐Autoimmune Disease ☐High Blood Pressure ☐Glaucoma ☐Other: ___________________	☐Cancer ☐Diabetes ☐Osteoporosis
Sibling	Y/N	____	☐Depression ☐Genetic Disease ☐Heart Attack ☐Stroke	☐Autoimmune Disease ☐High Blood Pressure ☐Glaucoma ☐Other: ___________________	☐Cancer ☐Diabetes ☐Osteoporosis
Sibling	Y/N	____	☐Depression ☐Genetic Disease ☐Heart Attack ☐Stroke	☐Autoimmune Disease ☐High Blood Pressure ☐Glaucoma ☐Other: ___________________	☐Cancer ☐Diabetes ☐Osteoporosis
Child	Y/N	____	☐Depression ☐Genetic Disease ☐Heart Attack ☐Stroke	☐Autoimmune Disease ☐High Blood Pressure ☐Glaucoma ☐Other: ___________________	☐Cancer ☐Diabetes ☐Osteoporosis
Child	Y/N	____	☐Depression ☐Genetic Disease ☐Heart Attack ☐Stroke	☐Autoimmune Disease ☐High Blood Pressure ☐Glaucoma ☐Other: ___________________	☐Cancer ☐Diabetes ☐Osteoporosis

Other Family History (grandparents, extended family):

Social History:

Education (highest level): _________

Occupation: ____________________

Marital Status
☐Single ☐Married ☐Partner
☐Widowed ☐Divorced

Exercise:
Type: _________________________
Frequency: _____________________

Tobacco
Do you use tobacco?
☐Yes ☐No ☐Past
How many packs per day? _____
How many cans per day? _____
How many years of use? _____
Year quit: _____

Drugs
Do you use recreational or street drugs?
☐Yes ☐No ☐Past

Alcohol
Do you use alcohol?
☐Yes ☐No
How many drinks per week? ___
Have you ever been treated for alcoholism?
☐Yes ☐No

Review of Systems: (check all symptoms you are concerned about that have occurred within the last 1 month) ☐ Not applicable

Constitutional
☐Fatigue
☐Fever
☐Night Sweats
☐Weight Change
☐Decreased Appetite

Eyes
☐Dry Eyes
☐Vision Change
☐Eye Pain

Ears/Nose/Mouth/Throat
☐Bleeding Gums
☐Dry Mouth
☐Mouth Ulcers
☐Hearing Loss
☐Ear Pain
☐Ringing in Ears
☐Frequent Nosebleeds
☐Runny Nose
☐Sinus Pressure
☐Hoarseness

Respiratory
☐Cough
☐Coughing Up Blood
☐Shortness of Breath
☐Wheezing

Cardiovascular
☐Chest Pain/Pressure
☐Irregular Heartbeats
☐Swelling/Edema
☐Shortness of Breath with Lying Down
☐Shortness of Breath with Exertion
☐Awakening Short of Breath

Genitourinary
☐Abnormal Vaginal Bleeding
☐Painful Urination
☐Incomplete Bladder Emptying
☐Urinary Frequency
☐Urinary Loss of Control

Gastrointestinal
☐Abdominal Pain
☐Nausea/Vomiting
☐Diarrhea
☐Constipation
☐Vomiting Blood
☐Black or Bloody Stool
☐Heartburn
☐Difficulty Swallowing
☐Hemorrhoids

Skin
☐Changes in Moles
☐Growth/Lesion
☐Rash
☐Itching
☐Yellowing of Skin

Musculoskeletal
☐Back Pain
☐Joint Pain
☐Muscle Aches
☐Muscle Weakness

Neurologic
☐Dizziness
☐Vertigo
☐Fainting
☐Seizure
☐Numbness/Tingling
☐Restless Legs
☐Weakness
☐Headaches

Endocrine
☐Increased Thirst
☐Intolerance to Heat
☐Intolerance to Cold

Psychiatric
☐Depression
☐Anxiety
☐Mania
☐Difficulty Sleeping

Hematologic/Lymphatic
☐Easy Bleeding/Bruising
☐Swollen Glands

Other Providers: (include all specialists and other health providers) ☐ Not applicable

Provider Name	Specialty
1.	
2.	
3.	

Durable Medical Equipment: (include names of companies providing medical equipment and supplies) ☐ Not applicable

Company Name	Supplies
1.	
2.	

Other Health History:

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Patient Signature: ______________________________ Date: ________________