

## Desert Peaks Health Care Health History Questionnaire

Patient Name (printed): \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Reason for Visit: \_\_\_\_\_

**Past Medical History:** (check all that apply)

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

<input type="checkbox"/> Colonoscopy	Date: _____	Provider/Location: _____
<input type="checkbox"/> Eye Examination	Date: _____	Provider/Location: _____
<input type="checkbox"/> Bone Density	Date: _____	Provider/Location: _____
<input type="checkbox"/> Mammogram	Date: _____	Provider/Location: _____
<input type="checkbox"/> Pap Smear	Date: _____	Provider/Location: _____

**Immunizations:**

<input type="checkbox"/> Gardasil/HPV #1	Date: _____	<input type="checkbox"/> MMR (measles, mumps, rubella)	Date: _____
<input type="checkbox"/> Gardasil/HPV #2	Date: _____	<input type="checkbox"/> Pneumonia/Prevnar-20	Date: _____
<input type="checkbox"/> Gardasil/HPV #3	Date: _____	<input type="checkbox"/> RSV	Date: _____
<input type="checkbox"/> Hepatitis A #1	Date: _____	<input type="checkbox"/> Tdap (tetanus with whooping cough)	Date: _____
<input type="checkbox"/> Hepatitis A #2	Date: _____	<input type="checkbox"/> Tetanus	Date: _____
<input type="checkbox"/> Hepatitis B #1	Date: _____	<input type="checkbox"/> Flu Shot	Date: _____
<input type="checkbox"/> Hepatitis B #2	Date: _____	<input type="checkbox"/> Shingles/Shingrix #1	Date: _____
<input type="checkbox"/> Hepatitis B #3	Date: _____	<input type="checkbox"/> Shingles/Shingrix #2	Date: _____
<input type="checkbox"/> Meningococcus	Date: _____		

**Family History:**

Relation	Alive	Age	Significant Health Problems		
Mother	Y/N		<input type="checkbox"/> Depression <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Heart Attack <input type="checkbox"/> Stroke	<input type="checkbox"/> Autoimmune Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Other:
Father	Y/N		<input type="checkbox"/> Depression <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Heart Attack <input type="checkbox"/> Stroke	<input type="checkbox"/> Autoimmune Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Other:
Sibling	Y/N		<input type="checkbox"/> Depression <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Heart Attack <input type="checkbox"/> Stroke	<input type="checkbox"/> Autoimmune Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Other:
Sibling	Y/N		<input type="checkbox"/> Depression <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Heart Attack <input type="checkbox"/> Stroke	<input type="checkbox"/> Autoimmune Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Other:
Sibling	Y/N		<input type="checkbox"/> Depression <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Heart Attack <input type="checkbox"/> Stroke	<input type="checkbox"/> Autoimmune Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Other:
Child	Y/N		<input type="checkbox"/> Depression <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Heart Attack <input type="checkbox"/> Stroke	<input type="checkbox"/> Autoimmune Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Other:
Child	Y/N		<input type="checkbox"/> Depression <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Heart Attack <input type="checkbox"/> Stroke	<input type="checkbox"/> Autoimmune Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Other:

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: \_\_\_\_\_

**Alcohol**

Do you use alcohol?

- Yes    No

How many drinks per week? \_\_\_\_\_

Have you ever been treated for alcoholism?

- Yes    No

**Drugs:**

Do you use recreational or street drugs?

- Yes    No    Past

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

Provider Name	Specialty
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

**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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**Are there any accommodations we could make to improve your appointment experience?**

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Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_