

**7070 Miller Rd. Suite A**  
**Swartz Creek, MI 48473**  
**Office: 810.564.7995, Opt. 4**  
**Fax: 810.221.1340**  
**Email: amdurgentcare@gmail.com**  
**Website: www.amdurgentcare.com**

# HEALTH HISTORY QUESTIONNAIRE

<b>Original Date:</b>
<b>Dates Revised:</b>
<i>This form is to be completed annually</i>

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

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

## PERSONAL HEALTH HISTORY

<b>Childhood illness:</b>	<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	
<b>Immunizations and dates:</b>	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>

**List any medical problems that other doctors have diagnosed**

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**Surgeries**

Year	Reason	Hospital

**Other hospitalizations**

Year	Reason	Hospital

# AMD



# PRIMARY CARE



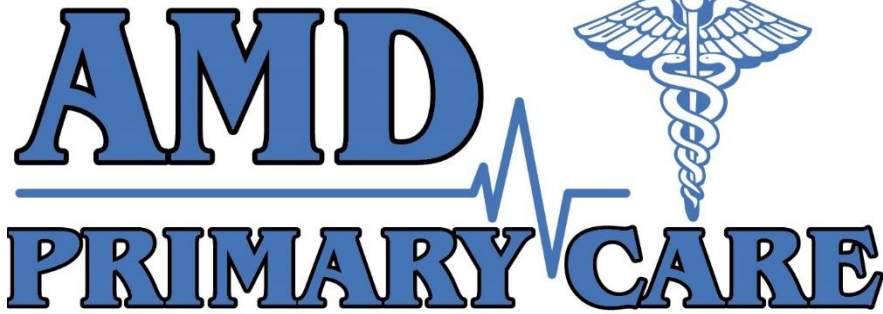
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<b>Have you ever had a blood transfusion?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, Please explain why?		

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

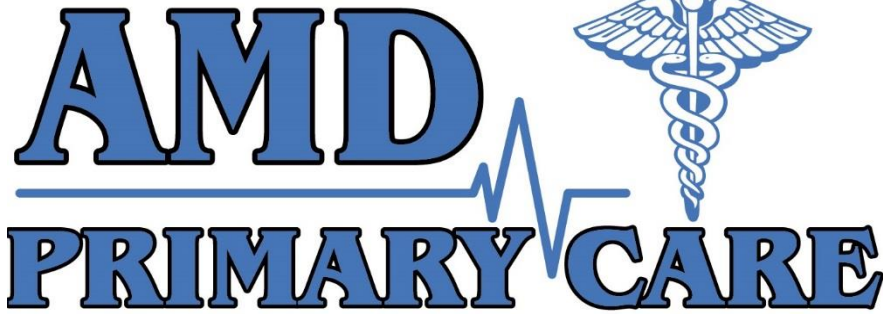
Allergies to medications	
Name the Drug	Reaction You Had

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HEALTH HABITS AND PERSONAL SAFETY					
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
<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?				
	Known food allergies?				
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low	
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	
	# of cups/cans per day?				
<b>Alcohol</b>	Do you drink alcohol?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	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
<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 - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit			
<b>Drugs</b>	Do you currently use recreational or street drugs?			<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
	Any discomfort with intercourse?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
<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 a personal safety issue you would like to discuss with your provider?			<input type="checkbox"/> Yes	<input type="checkbox"/> No



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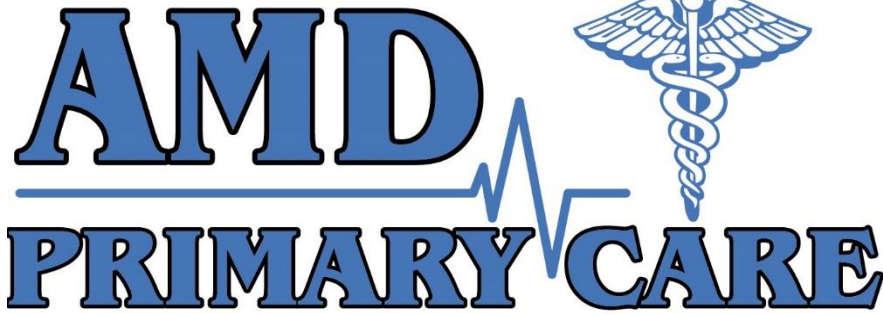
**FAMILY HEALTH HISTORY**

PLEASE DESCRIBE IN DETAIL ANY SIGNIFICANT HEALTH ISSUES INCLUDING, BUT NOT LIMITED TO, CANCER, DIEBETES, MENTAL ILLNESS, HEART ILLNESS, HIGH BLOOD PRESSURE, HIGH CHOLESTEROL, HISTORY OF STROKE, THYROID DISORDERS, IMMUNE DISORDERS, BLEEDING PROBLEMS, ASTHMA, ANEMIA, AUTOIMMUNE DISORDERS, AND KIDNEY DISEASE.

	AGE		SIGNIFICANT HEALTH PROBLEMS		AGE		SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>				<b>Children</b>	<input type="checkbox"/> M <input type="checkbox"/> F		
<b>Mother</b>					<input type="checkbox"/> M <input type="checkbox"/> F		
<b>Sibling</b>	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			<b>Grandmother</b> <i>Maternal</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<b>Grandfather</b> <i>Maternal</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<b>Grandmother</b> <i>Paternal</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<b>Grandfather</b> <i>Paternal</i>			

**MENTAL HEALTH**

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<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



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**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 ____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, 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, # 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

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**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"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<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"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

**ANY ADDITIONAL TOPICS OR CONCERNS YOU WOULD LIKE TO DISCUSS WITH YOUR PROVIDER:**

**MINOR'S ONLY**

With whom does the minor reside (please include all in the home including pets)?

Mother's Occupation: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_

Is the minor enrolled in school? What School? _____	What grade? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any concerns about school? <i>If Yes, Please Explain:</i>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any concerns about behavior at home or school? <i>If Yes, Please Explain:</i>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any concerns about cognitive development? <i>If Yes, Please Explain:</i>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there tobacco use in the home?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other drug use in the home?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any concern of violence in the home?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other concerns or issues you would like to discuss with your provider?		<input type="checkbox"/> Yes	<input type="checkbox"/> No