PERSONAL HEALTH HISTORY QUESTIONNAIRE DATE: _____ Health Care Provider: _____

Patient Name:	**Date of Birth**	**Age:**
Occupation:	**Employer:**	
With Whom Do You Live?	**On Whom Do You Depend On For Transportation?**	
Partner Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Significant Other ☐	**Preferred Pronouns:**	

FAMILY HISTORY

If any blood relative has suffered from any of the following, please check and indicate which relative in the space provided:

*Please List **ALL** Blood Relatives - GP= Grandparent, S= Sibling, M= Mother, F= Father*

☐ Alcoholism_____ ☐ Diabetes _____ ☐ Mental Illness_____ ☐ Stroke _____
☐ Anemia_____ ☐ Dementia _____ ☐ Migraine_____ ☐ Stomach Problems _____
☐ Autoimmune _____ ☐ Heart Disease_____ ☐ Osteoporosis_____ ☐ Breast Cancer _____
☐ Asthma_____ ☐ High Cholesterol_____ ☐ Seizures_____ ☐ Colon Cancer _____
☐ Clotting Disorders _____ ☐ Hypertension _____ ☐ Other Cancer _____

If Mother Deceased, Age & Cause of Death: _____

If Father Deceased, Age & Cause of Death: _____

HOSPITAL ADMISSIONS (Please Include **Pregnancies** & **Past Illnesses**)	**YEAR**	**ILLNESS/OPERATION**	**YEAR**	**ILLNESS/OPERATION**

List <u>Name & Dosage of All Medications</u> That You Are Taking Please Include: Prescriptions, Supplements, & Non-Prescription Drugs

1.	2.	3.
4.	5.	6.
7.	8.	9.

Preferred Pharmacy: Name & City

ALLERGIES Please List All Known Allergies, Especially to Medicines or Anesthesia WITH the reaction (ex: penicillin—Rash):

Please List The Month & Year Of Your Most Recent: Tests, Exams and Immunizations

Eye Exam:	DEXA Scan:	COVID-19 Vaccine:
Dental Exam:	Cholesterol Screen:	Shingles Vaccine (50 yrs. and older):
Colonoscopy/Stool Exam:	Other Labs:	Pneumonia Vaccine (65 yrs. and older):
Mammogram:	Flu Shot:	HPV:
PAP Smear:	Tetanus Shot (every 10 years):	

List Health Care Providers That You See Currently (Or Have Seen) For Your Major Medical Problems

Habits

☐ Smoking; #Cig/Day For Yrs. ☐ Alcohol; #Drinks/Day #Drinks/Mo. ☐ Caffeine; #Cups/Day

☐ Exercise; #Times/Week ☐ Marijuana: #Days/wk ☐ Other Substances: *(I.E. Chew, Illegal Drugs, etc.)*

ADVANCED CARE PLANNING:

☐ I have completed a POLST form/Advanced Directive ☐ I have NOT completed POLST form/Advanced

PLEASE CHECK THE ITEMS BELOW THAT YOU ARE EXPERIENCING NOW

HEENT
- ☐ Wear Glasses/Contacts
- ☐ Difficulty Seeing
- ☐ Difficulty Hearing
- ☐ Ringing in Ears
- ☐ Ear Wax Problems
- ☐ Dizziness
- ☐ Hay Fever
- ☐ Dental Problems

CV-RESP
- ☐ High Blood Pressure
- ☐ Leg Pain with Walking
- ☐ High Cholesterol/Triglyceride
- ☐ Anemia (Low Blood Count)
- ☐ Bleeding or Bruising Easily
- ☐ Heart Disease of Murmur
- ☐ Chest Pain
- ☐ Racing, Pounding Heart
- ☐ Blood Clots
- ☐ Ankle Swelling
- ☐ Shortness of Breath
- ☐ Lung or Breathing Problems
- ☐ Asthma/Wheezing
- ☐ Emphysema/COPD
- ☐ Chronic Cough
- ☐ Coughing Up Blood

GASTROINTESTINAL
- ☐ Chronic Abdominal Pain
- ☐ Frequent Nausea or Vomiting
- ☐ Bloody or Black Stools
- ☐ Heartburn
- ☐ Gallbladder Disease
- ☐ Swallowing Problem
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Rectal Bleeding
- ☐ Diarrhea/Constipation
- ☐ Change in Stool Size/Shape

GENITOURINARY
- ☐ Frequent Urinating
- ☐ Leaking Urine/Dribbling
- ☐ Urinating >1 Time at Night
- ☐ Pain or Blood on Urination
- ☐ Kidney Stone

SKIN
- ☐ Skin Disorders
- ☐ Rashes/Itching
- ☐ Acne
- ☐ Moles Changing Size/Color

NEURO
- ☐ Headaches
- ☐ Seizures
- ☐ Passing Out/Fainting
- ☐ Speech Problem
- ☐ Weakness or Paralysis
- ☐ Coordination Problem
- ☐ Tremors or Unsteadiness
- ☐ Memory/Thinking Problem

MUSCULAR
- ☐ Arthritis
- ☐ Gout
- ☐ Red/Swollen Joints
- ☐ Back or Neck Pain
- ☐ Painful Joints/Muscles/Bones
- ☐ Osteoporosis

METABOLIC
- ☐ Weight Gain
- ☐ Unexpected Weight Loss
- ☐ Unusual Fatigue
- ☐ Sleep Problems
- ☐ Diabetes (High Blood Sugar)
- ☐ Heat or Cold Intolerance
- ☐ Nervous or Anxious
- Unusual Hair Loss

MENTAL HEALTH
- ☐ Depression
- ☐ Anxiety
- ☐ Other Mental Illness

SEXUAL HEALTH
- ☐ Sexually Active
- ☐ Sexually Transmitted Diseases
- ☐ Sexual Concerns
- ☐ Painful Intercourse

Partner Type: _____

New Partners in Last 12 mo:_____

Birth Control
If Needed: _____

MALES ONLY
- ☐ Change in Urinary Stream
- ☐ Prostate Trouble
- ☐ Lumps on Testicles
- ☐ Difficulty with Erections

FEMALES ONLY

Age of First Menses: _____

Last Menstrual Cycle: _____

- ☐ Menstrual Trouble
- ☐ Abnormal Vaginal Discharge
- ☐ Abnormal Bleeding
- ☐ Difficulty Getting Pregnant
- ☐ Breast Lump or Pain
- ☐ Pain with Intercourse

MENOPAUSE
- ☐ Hormone Replacement
- ☐ Hot Flashes/Night Sweats

PREGNANCY RELATED
- #Pregnancies _____
- #Miscarriages _____
- #Abortions _____
- #C-Sections _____

- ☐ Pregnancy Complications
- ☐ Currently Pregnant

DO YOU HAVE OR HAVE YOU EVER HAD….?
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Rheumatic Fever
- ☐ Drug Addiction
- ☐ Alcohol Addiction

DO YOU HAVE ANY DIFFICULTY WITH ACCESS TO..?
- ☐ Food
- ☐ Housing
- ☐ Reliable Transportation
- ☐ Healthcare Coverage
- ☐ Support System

DO YOU FEEL UNSAFE AT HOME OR IN YOUR CURRENT ENVIRONMENT?
- ☐ Yes

PALOUSE MEDICAL P.S.
YOUR HEALTH PARTNER

Please fill in the blank with the number associated with your answer:
Not at all = 0pts, Several Days= 1 pt, More than half= 2 pt, Nearly Every Day= 3 pt

In the last 2 weeks, how often have you been bothered by:

1. Little interest or pleasure in doing things _____
2. Feeling down, depressed, or hopeless _____
3. Trouble falling, staying asleep, or sleeping too much _____
4. Feeling tired or having little energy _____
5. Poor appetite or overeating _____
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down _____
7. Trouble concentrating on things, such as reading the newspaper or watching television _____
8. Moving or speaking so slowly that other people could noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual _____
9. Thoughts that you would be better off dead or of hurting yourself in some way _____

TOTAL: _____ pts

WHAT QUESTIONS MAY I ANSWER FOR YOU CONCERNING YOUR HEALTH? ***

****Please be advised, issues assessed and treated outside chronic stable conditions are not considered preventative and additional charges may apply.*