



**Date:**

**Peter Christensen Health Center**

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To better prepare for your first appointment with us, please complete the following Health History Questionnaire and submit it prior to making your first appointment. Please also submit a ROI so that we may obtain your medical records prior to your visit. **These forms are required to better serve you.**

## MEDICAL HEALTH HISTORY QUESTIONNAIRE

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

<b>Name:</b>		<b>DOB:</b>	
<b>Gender Identity:</b>	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Transgender Male
	<input type="checkbox"/> Transgender Female	<input type="checkbox"/> Gender Queer	<input type="checkbox"/> Other
	<input type="checkbox"/> Declined		
<b>Sexual Orientation:</b>	<input type="checkbox"/> Straight	<input type="checkbox"/> Gay	<input type="checkbox"/> Lesbian
	<input type="checkbox"/> Bisexual	<input type="checkbox"/> Other	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Declined		
<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"/> Chicken Pox	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Polio
<b>Immunizations and dates:</b>						

List any medical problems that other doctors have diagnosed	
Year	Diagnosis

Surgeries:		
Year	Reason	Hospital

Other Hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Known Allergies (Medication and/or Environmental)	
Name of Allergy	Reaction You Had

**HEALTH HABITS AND PERSONAL SAFETY**

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL			
<b>Exercise</b> (check one that applies)	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 minutes)		<input type="checkbox"/>
	Regular vigorous exercise (i.e., work for recreation 4x/week for 30 minutes)		<input type="checkbox"/>
<b>Nutrition</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
	Number of meals you eat in an average day?		
	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
	Number of cups/cans per day		

<b>Alcohol</b>	Do you drink alcohol?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?				
	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
	Have you ever experienced blackouts?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you prone to "binge" drinking?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you drive after drinking?			<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 - cans/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day	
	<input type="checkbox"/> Number of years	<input type="checkbox"/> Or year quit			
	Commercial tobacco use (i.e. e-cig, vape, juul, etc.)			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?				
<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
	If yes, are you trying for a pregnancy?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier:				
	Any discomfort with intercourse?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illnesses like Human Immunodeficiency Virus (HIV), AIDS, and Hep C have become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?			<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 an Advance Directive or Living Will?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you feel safe in your home?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like to discuss physical, mental, or financial abuse?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

**FAMILY HEALTH HISTORY**

		Significant Health Problems (i.e. Heart Disease, Diabetes, Cancer, etc.)			Significant Health Problems (i.e. Heart Disease, Diabetes, Cancer, etc.)
		Age			Age
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
<b>Mother</b>				<input type="checkbox"/> M	
<b>Sibling</b>	<input type="checkbox"/> M		<input type="checkbox"/> F		
	<input type="checkbox"/> F		<input type="checkbox"/> M		
	<input type="checkbox"/> M		<input type="checkbox"/> F		
	<input type="checkbox"/> F		<input type="checkbox"/> M		
	<input type="checkbox"/> M		<input type="checkbox"/> F		
	<input type="checkbox"/> F		<b>Grandmother</b> <i>Maternal</i>		
	<input type="checkbox"/> M		<b>Grandfather</b> <i>Maternal</i>		
	<input type="checkbox"/> F		<b>Grandmother</b> <i>Paternal</i>		
<input type="checkbox"/> M		<b>Grandfather</b> <i>Paternal</i>			
<input type="checkbox"/> F					

**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
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**WOMEN ONLY**

Age at onset 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, number 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?		

**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	

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

PCHC Staff Signature: \_\_\_\_\_ Received Date: \_\_\_\_\_