Aspen Family Medicine at Green Valley Ranch

4809 Argonne Street Suite, 150
Denver, CO 80249

HEALTH HISTORY QUESTIONNAIRE

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

Name_____ ___ _____ Male____ Female____ DOB_____
Marital Status: ____Single ____Partnered ____ Married ____Separated ____Divorced ____Widowed
Previous or referring doctor: _____ **Date of last physical exam**: _____

PERSONAL HEALTH HISTORY

Childhood Illness: ____ Measles _____Mumps _____Rubella _____Chickenpox _____Polio
Immunizations/dates _____Tetanus _____ Hepatitis _____Influenza
_____ Pneumonia_____ Chickenpox _____MMR

List any medical problems that other doctors have diagnosed:_____

Surgeries

Year	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other hospitalizations

Year	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had a blood transfusion?_____ _____Yes _____No

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
_____	_____
_____	_____
_____	_____

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Exercise
___ Sedentary (No exercise)
___ Mile exercise, (i.e., work or recreation, less than 4x/week for 30 min.)
___ Occasional vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)
___ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet
___ Are you dieting?
___ If yes, are you on a physician prescribed medical diet?
___ # of meals you eat in an average day?
___ Rank salt intake ___Hi ___Med ___Low
___ Rank fat intake ___Hi ___Med ___Low

Caffeine ___None ___Coffee ___Tea ___Cola ___# of cups/cans per day?_____

Alcohol
Do you drink alcohol? ____ Yes ____ No
If yes, what kind?_____
How many drinks per weeks? _____
Are you concerned about the amount you drink? ____ Yes ____ No
How you considered stopping? ____ Yes ____ No
Have you ever experienced blackouts? ____ Yes ____ No
Are you prone to "binge" drinking? ____ Yes ____ No
Do you drive after drinking? ____ Yes ____ No

Tobacco
Do you use tobacco? ____ Yes ____ No
_____Cigarettes – pks./day ____ Chew - #/day _____ Pipe-#/day _____ Cigars-#/day
_____# of years _____ Or year quit

Drugs
Do you currently use recreational or street drugs? ____ Yes ____ No
Have you ever given yourself street drugs with a needle? ____ Yes ____ No

Sex	Are you sexually active?	____ Yes	____ No
	If yes, are you trying for a pregnancy?	____ Yes	____ No
	Any discomfort with intercourse?	____ Yes	____ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has 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?	____ Yes	____ No
Personal Safety	Do you live alone?	____ Yes	____ No
	Do you have frequent falls?	____ Yes	____ No
	Do you have vision or hearing loss??	____ Yes	____ No
	Do you have Advanced Directive or Living Will?	____ Yes	____ No
	Would you like information on the preparation of these?	____ Yes	____ No
	Physical and/or mental abuse have also become major public issues in this country. This often takes the form of verbal threating behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	____ Yes	____ No

FAMILY HEALTH HISTORY

	Age	Significant Health Problems		Age	Significant Health Problems
Father	_____	_____		___M	_____
Mother	_____	_____	**Children**	___F	_____
				___M	_____
				___F	_____
Sibling	___M	_____		___M	_____
	___F	_____		___F	_____
	___M	_____		___M	_____
	___F	_____		___F	_____
	___M	_____	**Grandmother**	___	_____
	___F	_____	(*Maternal)*	___	_____
	___M	_____	**Grandfather**	___	_____
	___F	_____	(*Maternal)*	___	_____
	___M	_____	**Grandmother**	___	_____
	___F	_____	*(Paternal)*	___	_____
	___M	_____	**Grandfather**	___	_____
	___F	_____	*(Paternal)*	___	_____

MENTAL HEALTH

Is stress a major problem for you?	____ Yes	____ No
Do you feel depressed?	____ Yes	____ No
Do you panic when stressed?	____ Yes	____ No
Do you have problems with eating or your appetite?	____ Yes	____ No
Do you cry frequently?	____ Yes	____ No
Have you ever attempted suicide?	____ Yes	____ No
Have you ever seriously thought about hurting yourself?	____ Yes	____ No
Do you have trouble sleeping?	____ Yes	____ No
Have you ever been to a counselor?	____ Yes	____ No

WOMEN ONLY

Age of onset menstruation: _____

Date of last menstruation: _____

Period every_____ days_____

Heavy periods, irregularity, spotting, pain, or discharge?	____ Yes	____ No
Number of pregnancies ____ Number of live births? _____	____ Yes	____ No
Are you pregnant or breastfeeding?	____ Yes	____ No
Have you had a D&C, hysterectomy, or Cesarean?	____ Yes	____ No
Any urinary tract, bladder, or kidney infections within the last year?	____ Yes	____ No
Any blood in your urine?	____ Yes	____ No
Any problems with control of urination?	____ Yes	____ No
Any hot flashes or sweating at night?	____ Yes	____ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around the time of period?	____ Yes	____ No
Experienced any recent breast tenderness, lumps or nipple discharge?	____ Yes	____ No
Date of last pap and rectal exam?	____ Yes	____ No

MEN ONLY

Do you usually get up to urinate during the night?	____ Yes	____ No
If yes, # of times_____		
Do you feel pain or burning with urination?	____ Yes	____ No
Any blood in your urine?	____ Yes	____ No
Do you feel burning discharge from penis?	____ Yes	____ No
Has the force of your urination decreased?	____ Yes	____ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	____ Yes	____ No
Do you have any problems emptying your bladder completely?	____ Yes	____ No
Any difficulty with erection or ejaculation?	____ Yes	____ No
Any testicle pain or swelling?	____ Yes	____ No
Date of last prostate and rectal exam?	____ Yes	____ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to significant degree and briefly explain.

___Skin	___Chest/Heart	___Recent changes in:
___Head/Neck	___Back	___Weight
___Ears	___Intestinal	___Energy Level
___Nose	___Bladder	___Ability to sleep
___Throat	___Bowel	___Other pain/discomfort? Please describe below
___Lungs	___Circulation	_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Signature of Patient/Parent/Guardian: _____ Date: _____