Johnson Health Center – Health History Questionnaire **Date_____**

Name_____Age_____Date of Birth_____ Single Married Divorced Widow(er)

Birthplace_____List all states/countries in which you have lived_____

Occupation_____List previous occupations_____

Education _____years through high school _____years of college _____years post-graduate

Date of last physical exam_____

Advance Directive

Please list all current symptoms:

Discussed Y N

1._____ Patient has directive Y N

2._____ Directive on file Y N

3._____ ALLERGIES: _____

Routine checkup – no problems _____ _____

Family History					
If Living:		**If Deceased:**		**Has any blood relative ever had:**	
	Age **Health**	**Age at Death**	**Cause of Death**	**Please circle Y or N**	**Who?**
Father				Allergies Y N	
Mother				Asthma Y N	
Brother or Sister 1				Arthritis Y N	
Brother or Sister 2				Cancer Y N	
Brother or Sister 3				Diabetes Y N	
Brother or Sister 4				Epilepsy Y N	
				Glaucoma Y N	
Spouse or Partner				Heart disease Y N	
Son or Daughter 1				High blood pressure Y N	
Son or Daughter 2				Stroke Y N	
Son or Daughter 3				Suicide Y N	
Son or Daughter 4					
Son or Daughter 5					

Personal History
Circle any items below that apply to you

Red Measles
German measles
Mumps
Chicken Pox
Whooping Cough
Scarlet Fever
Pneumonia
Influenza
Rheumatic Fever
Arthritis/Rheumatism
Heart disease
Bone or Joint disease
Neuritis or neuralgia
Bursitis, Sciatica or Lumbago
Polio
Meningitis
Kidney Infections
Gonorrhea/syphilis
Anemia
Yellow Jaundice
Epilepsy
Migraine Headaches
Tuberculosis
Diabetes
Cancer

High blood pressure
Low blood pressure
Nervous breakdown
Food, chemical or drug poisoning
Hay fever
Asthma
Hives

Eczema
Frequent infections or boils
Other _____

Broken or cracked bones
Severe cuts or lacerations
Dislocations
Concussion or head injury
Victim of violence

Allergies:
Penicillin or sulfa
Aspirin, codeine, or morphine
Erythromycin
Other antibiotics_____
Other drugs_____
Adhesive tape
Latex

Please complete reverse side

Have you ever had a blood or plasma transfusion? _____

Weight:_____Now_____One year ago
Desired weight: _____

Average hours of sleep per night _____
Do you wake refreshed?_____
Do you snore?_____

Alcohol use:
Never 1 -2 drinks/week 3–6 per week
7-24 per week more than 24
Ever been treated for alcoholism? _____

Tobacco use:
___Never ___Former ___Current
___Cigarettes ___Cigar ___Pipe ___Chew
How much per day?_____
For how long?_____

Do you exercise?_____
How often?_____
In what way?_____

System Review
Circle any items below that apply to you.
Do you have or have you ever had:

Eye disease, injury or impaired sight
Ear disease, injury or impaired hearing
Any trouble with nose, sinuses, or mouth
Fainting spells or dizziness
Convulsions or seizures
Paralysis or numbness
Frequent or severe headaches
Difficulty remembering or concentrating
Frequent crying spells
Difficulties related to work or family problems
Thoughts about committing suicide
Enlarged glands
Enlarged thyroid or goiter
Skin problems
Chronic or frequent cough
Chest pain or angina pectoris
Coughing or spitting up blood
Night sweats
Shortness of breath
Palpitations or fluttering heart
Heart murmur
Swelling of hands, feet or ankles
Varicose veins
Extreme tiredness or weakness
Kidney stones
Bladder infections
Protein, sugar or blood in urine
Difficulty urinating
Getting up frequently at night to urinate
Abnormal thirst
Stomach trouble or ulcers
Indigestion or heartburn
Liver or gall bladder disease
Colitis or other bowel problems
Hemorrhoids or rectal bleeding
Constipation or diarrhea
Recent change in appetite or eating habits
Recent change in bowel habits or stools
Recent change in weight (up or down)
Stiff, swollen, or painful joints
Lumps in your breasts
Sexual difficulties
Sex is not entirely satisfactory
Genital warts

Surgeries (circle)

Tonsillectomy Appendectomy Gall Bladder
D & C Cesarean Section Hysterectomy
Other operations (type, date, where done):_____
_____
_____

Women Only

Menstrual History: Age at onset _____

Periods are: regular irregular none

Flow is: light medium heavy

Cycle length is _____ days.

Do you have _____pain _____cramps

Date of last period _____

Total number of pregnancies _____

Date of last Pap smear _____

Have you ever had an abnormal Pap? _____

Date of last mammogram _____

Men Only

Ever had swelling or lumps in your testicles?_____

Do you have difficulty starting your flow of urine? _____

Drug Use

Do you use:

Marijuana	never	occasionally	regularly
Cocaine	never	occasionally	regularly
Other street drugs	never	occasionally	regularly
Laxatives	never	occasionally	regularly
Vitamins	never	occasionally	regularly
Tranquilizers	never	occasionally	regularly
Sleeping pills	never	occasionally	regularly
Aspirin	never	occasionally	regularly
Cortisone/steroids	never	occasionally	regularly
Appetite suppressants never	occasionally	regularly	
Herbal supplements	never	occasionally	regularly

Present Medications

Please list all current prescription drugs and supplements you use:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____

Patient Signature Date

_____

Provider Signature Date