Accessible Family Clinic

3307 Spring Stuebner Rd Ste. A1 Spring, TX 77389 281-528-2273

HEALTH HISTORY QUESTIONNAIRE - ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL AND WILL BECOME PART OF YOUR MEDICAL RECORD

How did you hear about our clinic?

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	

Address: **City:** **State:** **Zip:** **Phone:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates: (If you do not remember the dates you received these immunizations, please write UP TO DATE next to it.)	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

ALL Surgeries or Other hospitalizations

Year	Reason	Hospital

MENTAL HEALTH

Do you have a problem with any of the following?	☐ trouble sleeping ☐ been to a counselor ☐ suicidal ☐ depression
	☐ panic when stressed ☐ problems with eating ☐ frequent crying

List prescribed drugs and over-the-counter drugs, ex. Vitamins,

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)			
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	Are you dieting? ☐ yes ☐ no	If yes, are you on a physician prescribed medical diet? ☐ yes ☐ no		
	# of meals you eat in an average day?			
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Sodas # cups/cans per day?

Alcohol	Do you drink alcohol? ☐ yes ☐ no	what kind?	How many per week?	
Tobacco	Do you use tobacco? ☐ yes ☐ no	# of years?		
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
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		Are you pregnant or trying? ☐ yes ☐ no	
	List contraceptive or barrier method used:			
	Any discomfort with intercourse?			☐ yes ☐ no

FAMILY HEALTH HISTORY- ONLY LIST SIGNIFICANT HEALTH PROBLEMS

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F		**Grandparent** *Maternal*		
	☐ M ☐ F		**Grandparent** *Paternal*		

OTHER PROBLEMS

Check any symptoms that apply, past or present 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:
☐ Lungs	☐ Circulation	

WOMEN ONLY

Age at onset of menstruation:	Date of last menstruation:	Period every _____ days
☐ Heavy periods ☐ irregularity ☐ spotting ☐ pain ☐ discharge		
Number of pregnancies _____ Number of live births _____		Are you pregnant or breastfeeding? ☐ yes ☐ no
Have you had any of the following: ☐ D&C ☐ hysterectomy ☐ Cesarean ☐ blood in your urine ☐ hot flashes		
☐ problems w/ control of urination ☐ night sweats ☐ breast tenderness ☐ lumps ☐ nipple discharge		
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? ☐ yes ☐ no		
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night? ☐ yes ☐ no	If yes, # of times _____	
Do you have any of the following: ☐ pain or burning w/ urination ☐ discharge ☐ blood in urine ☐ decrease force in urination		
☐ testicular pain or swelling ☐ difficulty with erection ☐ bladder, kidney, prostate infections		
Date of last prostate and rectal exam?		