



HEALTH HISTORY QUESTIONNAIRE

AFFM annually asks these questions about your health information to stay updated to any changes in order to provide to you the best medical care.

Name:

_____ M F
Last First MI DOB (mm-dd-yyyy) Today's Date

Marital Status: Single Partnered Married Separated Divorced Widowed

Previous or Referring Doctor: _____ Date of Last Physical Exam: _____

LIST YOUR REASONS FOR COMING TO SEE THE DOCTOR TODAY:

PERSONAL HEALTH HISTORY

List Any New Medical Problems That Other Doctors Have Diagnosed:

List Any/New Surgeries:

Date	Procedure	Reason	Hospital

List Any/New Hospitalizations:

Date	Procedure	Reason	Hospital

List Any/New Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Name of Drug	Dose Strength	Frequency Taken

List Any/New Food and Medication Allergies:

Name of Food/Drug	Reaction(s) You Had
	<input type="checkbox"/> Difficulty breathing/Throat swelling <input type="checkbox"/> Rash and/or hives <input type="checkbox"/> Other
	<input type="checkbox"/> Difficulty breathing/Throat swelling <input type="checkbox"/> Rash and/or hives <input type="checkbox"/> Other
	<input type="checkbox"/> Difficulty breathing/Throat swelling <input type="checkbox"/> Rash and/or hives <input type="checkbox"/> Other

FAMILY HEALTH HISTORY

FAMILY HEALTH HISTORY				
<input type="checkbox"/> ADOPTED Unknown Family History	Current Age	Age at Death & Cause	<i>Check Box if Family Member has any of the following:</i>	
Father First Name: Year Born:			<input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack(s) <input type="checkbox"/> Stroke <input type="checkbox"/> Obesity	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> Depression <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Psychiatric illness <input type="checkbox"/> Cancer – If so, what kind(s)?
Mother First Name: Year Born:			<input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack(s) <input type="checkbox"/> Stroke <input type="checkbox"/> Obesity	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> Depression <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Psychiatric illness <input type="checkbox"/> Cancer – If so, what kind(s)?
Grandfather (maternal) First Name: Year Born:			<input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack(s) <input type="checkbox"/> Stroke <input type="checkbox"/> Obesity	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> Depression <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Psychiatric illness <input type="checkbox"/> Cancer – If so, what kind(s)?
Grandmother (maternal) First Name: Year Born:			<input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack(s) <input type="checkbox"/> Stroke <input type="checkbox"/> Obesity	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> Depression <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Psychiatric illness <input type="checkbox"/> Cancer – If so, what kind(s)?
Grandfather (paternal) First Name: Year Born:			<input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack(s) <input type="checkbox"/> Stroke <input type="checkbox"/> Obesity	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> Depression <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Psychiatric illness <input type="checkbox"/> Cancer – If so, what kind(s)?
Grandmother (paternal) First Name: Year Born:			<input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack(s) <input type="checkbox"/> Stroke <input type="checkbox"/> Obesity	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> Depression <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Psychiatric illness <input type="checkbox"/> Cancer – If so, what kind(s)?
Brother(s) First Name(s): Year(s) Born:	# Alive	# Deceased	<input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack(s) <input type="checkbox"/> Stroke <input type="checkbox"/> Obesity	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> Depression <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Psychiatric illness <input type="checkbox"/> Cancer – If so, what kind(s)?
Sister(s) First Name(s): Year Born:	# Alive	# Deceased	<input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack(s) <input type="checkbox"/> Stroke <input type="checkbox"/> Obesity	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> Depression <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Psychiatric illness <input type="checkbox"/> Cancer – If so, what kind(s)?
Your Children First Name(s): Year(s) Born:	# Alive	# Deceased	<input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack(s) <input type="checkbox"/> Stroke <input type="checkbox"/> Obesity	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> Depression <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Psychiatric illness <input type="checkbox"/> Cancer – If so, what kind(s)?

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

- Date of last pap smear and rectal exam? _____ Date of last menstruation: _____
- Age at onset of menstruation: _____ Period every _____ days.
- Number of pregnancies: _____ Number of live births: _____
- Have you had a D&C, tubal ligation, hysterectomy, or Cesarean section? Yes No
- Are you pregnant or breastfeeding? Yes No

Check symptoms you currently have or have had IN THE PAST YEAR

- | | | | |
|---|--|---|---|
| <p style="text-align: center;">GENERAL</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Depression/Nervousness</p> <p><input type="checkbox"/> Dizziness/Fainting</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Forgetfulness</p> <p><input type="checkbox"/> Headache</p> <p><input type="checkbox"/> Loss of sleep</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Sweats</p> | <p style="text-align: center;">GASTROINTESTINAL</p> <p><input type="checkbox"/> Appetite poor</p> <p><input type="checkbox"/> Bloating</p> <p><input type="checkbox"/> Bowel changes</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Excessive thirst</p> <p><input type="checkbox"/> Gas</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Rectal bleeding</p> <p><input type="checkbox"/> Stomach pain</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Vomiting blood</p> | <p style="text-align: center;">EYE, EAR, NOSE, THROAT</p> <p><input type="checkbox"/> Bleeding gums</p> <p><input type="checkbox"/> Blurred vision</p> <p><input type="checkbox"/> Crossed eyes</p> <p><input type="checkbox"/> Difficulty swallowing</p> <p><input type="checkbox"/> Double vision</p> <p><input type="checkbox"/> Earache/Ear discharge</p> <p><input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Loss of hearing</p> <p><input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> Persistent cough</p> <p><input type="checkbox"/> Ringing in ears</p> <p><input type="checkbox"/> Sinus problems</p> <p><input type="checkbox"/> Vision – Flashes/Halos</p> | <p style="text-align: center;">MEN ONLY</p> <p><input type="checkbox"/> Erection difficulties</p> <p><input type="checkbox"/> Lump in testicles</p> <p><input type="checkbox"/> Penis discharge</p> <p><input type="checkbox"/> Sore on penis</p> <p><input type="checkbox"/> Other</p> |
| <p style="text-align: center;">MUSCLE/JOINT/BONE</p> <p>Pain, weakness, numbness in:</p> <p><input type="checkbox"/> Arms <input type="checkbox"/> Hips</p> <p><input type="checkbox"/> Back</p> <p><input type="checkbox"/> Feet</p> <p><input type="checkbox"/> Hands</p> | <p style="text-align: center;">CARDIOVASCULAR</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> High/Low blood pressure</p> <p><input type="checkbox"/> Irregular/Rapid heart beat</p> <p><input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> Swelling of ankles</p> <p><input type="checkbox"/> Varicose veins</p> | <p style="text-align: center;">SKIN</p> <p><input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Itching/Rash</p> <p><input type="checkbox"/> Changes in moles</p> <p><input type="checkbox"/> Scars</p> <p><input type="checkbox"/> Sore that won't heal</p> | <p style="text-align: center;">WOMEN ONLY</p> <p><input type="checkbox"/> Abnormal Pap Smear</p> <p><input type="checkbox"/> Bleeding b/n periods</p> <p><input type="checkbox"/> Breast lump</p> <p><input type="checkbox"/> Extreme menstrual pain</p> <p><input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> Painful intercourse</p> <p><input type="checkbox"/> Vaginal discharge</p> <p><input type="checkbox"/> Other</p> |

OTHER PROBLEMS

List any other concerns or issues you may have and wish to discuss with the doctor: