HEALTH HISTORY QUESTIONNAIRE
EXECUTIVE HEALTH PROGRAM

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

PERSONAL INFORMATION

Name *(Last, First, MI)*		☐ M ☐ F	**DOB:**	
Marital Status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Primary doctor:		**Primary doctor phone:**		
Primary doctor address:				

PERSONAL HEALTH HISTORY

Childhood Illnesses:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Asthma ☐ Other (please list):	
Immunizations and dates if known:	☐ Tetanus Tdap or Td Date ________ ☐ Hepatitis A and/or B Date ________ ☐ Influenza Date ________ ☐ Pneumonia (PCV13, Pneumovax) Date ________	☐ Chickenpox (varicella) Date ________ ☐ Shingles (Shingrix or Zostavax) Date ________ ☐ MMR Measles, Mumps, Rubella Date ________

What can we do for you at your exam?

Do you have any other medical questions or concerns?

Colonoscopy:	Year completed:	Results:
Repeat:	☐ 5 years ☐ 10 years ☐ Other:	
Procedure facility:		

List medical problems in your past that other doctors have diagnosed, conditions that you take medication for (i.e. hypertension, or high cholesterol), including hospitalizations.

Year	Diagnosis or medical problem

Surgeries

Year	Type of procedure

Have you ever had a blood transfusion? ☐ Yes ☐ No

QUESTIONNAIRE, PATIENT = 100058

Your pharmacy and location:	

List prescribed drugs and all over-the-counter drugs, such as vitamins/supplements and inhalers:

Name of medication	Strength	Frequency taken

Allergies to the medications:

Name of medication	Reaction you had

HEALTH HABITS AND PERSONAL SAFETY

Are you a Blood Donor? ☐ Yes ☐ No		Approximate date of last donation:	
Exercise:	See 7-Day Diet/Exercise Log	**Diet:**	See 7-Day Diet/Exercise Log
Caffeine:	☐ None ☐ Coffee ☐ Tea ☐ Soda	# of cups/cans per day:	
Do you drink alcohol? ☐ Yes ☐ No If yes, what kind?		How many drinks per week?	

Do you currently use tobacco products? ☐ Yes ☐ No	If yes, please check all that apply:
Were you ever a smoker? ☐ Yes ☐ No	☐ Cigarettes: pks/day ____________
When did you quit?	☐ Chew: #/day____________
How many years have/did you use tobacco?	☐ Pipe: #/day____________
Do you use vaping products? ☐ Yes ☐ No	☐ Cigars: #/day ____________
	☐ Other ____________
If yes, specify what you are vaping:	

OTHER PROBLEMS

☐ Skin (complete Derm section)	☐ Chest/heart	☐ Weight
☐ Eye (complete Eye section)	☐ Back	☐ Energy level
☐ Head/neck	☐ Joint problems	☐ Ability to sleep
☐ Ears	☐ Heartburn	☐ Other pain/discomfort:
☐ Nose	☐ Bladder	
☐ Throat	☐ Bowel habits	☐ Recent changes in:
☐ Lungs	☐ Circulation	

MALE

Have you experienced:	Number of times up to urinate during night:	
Prostate concerns? ☐ Yes ☐ No	Other concern not listed:	
Difficulty with erection or ED? ☐ Yes ☐ No		
Difficulty urinating? ☐ Yes ☐ No		
Do you perform testicular self-exam? ☐ Yes ☐ No		

Sexual History:			
Current partner:	☐ Male ☐ Female ☐ Both ☐ None	Do you have pain with intercourse?	☐ Yes ☐ No ☐ Not active
Do you have any other sexual concerns?			
History of sexual, physical, or mental abuse?	☐ Yes ☐ No	If yes, is it still occurring?	☐ Yes ☐ No
Do you feel safe at home?	☐ Yes ☐ No		

FEMALE

Have you experienced:	Do you have a gynecologist? ☐ Yes ☐ No	
Difficulty urinating? ☐ Yes ☐ No	If yes, GYN name?	
Urinary leakage? ☐ Yes ☐ No	List last menstural date:	
Abnormal Mammogram? ☐ Yes ☐ No	Life stage: ☐ Pre-menopause ☐ Peri-menopause ☐ Menopause ☐ Post-menopause	
Do you do breast self-exams? ☐ Yes ☐ No		
Abnormal pap? ☐ Yes ☐ No	Other concern not listed:	
Have you had a hysterectomy? ☐ Yes, what year?________ ☐ No		
Pre-eclampsia or pregnancy complication? ☐ Yes ☐ No		

Menstrual Cycle History			
Age you started menstruating:			
If you are still having menstrual cycles:			
How many days from the start of your menses to the start of your next menses?		Number of days you bleed with your menses:	
Pain with menses?	☐ Mild ☐ Moderate ☐ Severe ☐ None	Amount of bleeding:	☐ Mild ☐ Moderate ☐ Severe
If you are postmenopausal:			
Do you use postmenopausal systemic hormones (pills or patches)	☐ Never ☐ In the past ☐ Current	How many years?	

Birth Control:	Do you currently use birth control? ☐ Yes ☐ No ☐ Not sexually active
If yes, what do you use?	☐ Oral pills ☐ Patches ☐ Condoms ☐ Depo-Provera ☐ IUD ☐ Nuvaring ☐ Implant Diaphragm ☐ Rhythm ☐ Sponge Surgical: ☐ Tubal ligation ☐ Essure ☐ Hysterectomy ☐ Vasectomy

Do you have a history of any of the following conditions:

Gonorrhea (GC)	☐ Yes ☐ No	Syphilis	☐ Yes ☐ No	Other sexually transmitted infection	☐ Yes ☐ No
Chlamydia	☐ Yes ☐ No	Hepatitis B	☐ Yes ☐ No	List:	
Herpes	☐ Yes ☐ No	HIV or AIDs	☐ Yes ☐ No		

FEMALE - *continued*

Sexual History:

Current partner: ☐ Male ☐ Female ☐ Both ☐ None	Do you have pain with intercourse?	☐ Yes ☐ No ☐ Not active
Do you have any other sexual concerns?		
History of sexual, physical, or mental abuse? ☐ Yes ☐ No	If yes, is it still occurring?	☐ Yes ☐ No
Do you feel safe at home? ☐ Yes ☐ No		

Pregnancies:

Have you had a pregnancy?	☐ Yes ☐ No	Number of pregnancies:		Number of children delivered:	
Multiple Births:	Number of twins:		Number of triplets:	Other multiple gestations:	
Number delivered at full term (36+ weeks):		Number delivered before 36 weeks:			
Number of Cesarean sections (C sections):		Number of children living:			
Number of induced abortions:		Number of spontaneous abortions:			

FAMILY HEALTH HISTORY - *All Patients*

Relative		Alive or Deceased	Age at death	List Medical Problems and Age of Onset (High blood pressure, high cholesterol, diabetes, any cancers, heart problems)
Mother				
Father				
Siblings	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
Children	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
Grandmother *Maternal*				
Grandfather *Maternal*				
Grandmother *Paternal*				
Grandfather *Paternal*				

If any cancers run in your family outside the listed immediate relatives, please identify: (i.e. paternal uncle)

Relative	Cancer type

Have you ever had genetic analysis for medical or health concerns? ☐ Yes ☐ No

If yes, when?____________________

Would you like to meet with a genetic counselor about these results? ☐ Yes ☐ No

SKIN/DERMATOLOGY

Personal skin concern or condition:

Past skin cancer surgery:	Date:		Physician:		Facility:	
	Affected body area:			Was Mohs performed? ☐ Yes ☐ No		

Are there skin conditions that run in your family? *Check all that apply*	☐ Melanoma	☐ Psoriasis
	☐ Other skin cancers	☐ Other skin conditions

Sun Exposure:

Have you had extensive sun exposure? ☐ Yes ☐ No	Do you wear sunscreen? ☐ Yes ☐ No
How many blistering sunburns have you had? ☐ Yes ☐ No	If so, do you wear it daily? ☐ Yes ☐ No
	What SPF (sun protection factor)?

OPHTHALMOLOGY/OPTICAL QUESTIONS

Personal eye concern or condition:

Eye History	Personal	Family	Eye History	Personal	Family
Amblyopia (lazy eye)	☐ Yes ☐ No	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	☐ Yes ☐ No	Macular degeneration	☐ Yes ☐ No	☐ Yes ☐ No
Color blindness	☐ Yes ☐ No	☐ Yes ☐ No	Retinal detachment	☐ Yes ☐ No	☐ Yes ☐ No
Diabetic retinopathy	☐ Yes ☐ No	☐ Yes ☐ No	Other:	☐ Yes ☐ No	☐ Yes ☐ No
Eye injury	☐ Yes ☐ No	☐ Yes ☐ No	Other:	☐ Yes ☐ No	☐ Yes ☐ No

Patient Signature: ______________________________ Date/Time: ________________