Health Questionnaire

Patient Name: ________________________ ***Today's Date:*** ________________

Welcome to the Diabetes and Lipid Clinic of Alaska. Our intention is to obtain a complete picture of your health history and lifestyle choices. We understand our form is time-consuming and appreciate your patience. Please be as accurate and honest as you can. Some of these questions are of a personal nature; please rest assured the information you share will be protected with the strictest confidentiality. Please let us know if you need clarification on any of the questions.

Health Concerns:

1. What is your primary health concern? ________________________

2. How long has this problem been present? How frequent? How severe? ________________________

3. Where in your body do you experience this problem? Any change of location since it began? ________________________

4. Has the problem gotten better or worse or changed with time? In what way? ________________________

5. Are there any associated symptoms or problems? ________________________

6. What treatments have been tried so far (either your own efforts or with another healthcare professional)? Any response? ________________________

7. What do you hope to accomplish with today's visit? ________________________

8. Any other current health problems? ________________________

Current Medications:

Drug Name	Dosage	Frequency	How Long You've Taken It	Prescribing Physician

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Current Over-The-Counter Medications and Supplements:

OTC Medication / Supplement Name	Dosage	Frequency	How Long You've Taken It

Allergies:

☐ No Known Drug Allergies ***OR***

Name of Drug	Reaction

Personal/Family Medical History: Place a check (✓) whether you have had any of the following medical problems and list family members who have had these illnesses.

	Self Present or Past		Family Present or Past		Specify Relationship
Addiction	☐		☐		
Diabetes	☐		☐		
Heart Disease	☐		☐		
Stroke	☐		☐		
High Cholesterol	☐		☐		
High Blood Pressure	☐		☐		
Thyroid Problem	☐		☐		
Rheumatic Fever	☐		☐		
Cancer, Type: ____________	☐		☐		
Mental Health Problems	☐		☐		
Seizures	☐		☐		
Lung Disease	☐		☐		
Migraines	☐		☐		
Kidney Disease	☐		☐		
Osteoporosis	☐		☐		
Clotting or Bleeding Disorder	☐		☐		
Infectious Disease:________	☐		☐		
Arthritis, Type:____________	☐		☐		

Other serious health issues: ____

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Surgeries:____

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Patient Name: ______________________________ Today's Date: ________________________

Health Screening Exams : Check-off the ones that you have done and write in the year last done

General:	☐ Chest X-Ray:____________	☐ EKG:______________________________	☐ Stress Test:__________
	☐ Echocardiogram:__________	☐ Colonoscopy/Sigmoidoscopy:__________	☐ Eye Exam:___________
	☐ Dental Exam:____________		
Women:	☐ Pap Smear:_____________	☐ Mammogram:______________________	☐ Pelvic Ultrasound:______
	☐ Breast Exam:____________		
Men:	☐ PSA Blood Test:__________	☐ Prostate Exam:____________________	
Vaccines:	☐ Tetanus/Tdap:___________	☐ Pneumonia:_______________________	☐ Influenza:____________
	☐ Shingles:______________	☐ Hepatitis A:_______________________	☐ Hepatitis B:___________
	☐ HPV:__________________		

More About You:

1. Tobacco Use? ☐ No ☐ Yes, How much for how long? ______________________________
2. Alcohol Use? ☐ No ☐ Yes, How much for how long? ______________________________
3. Caffeine Use: ☐ No ☐ Yes, Quantity? ______________________________
4. Recreational Drugs? ☐ No ☐ Yes, How much for how long? ______________________________
5. Use seat belts? ☐ No ☐ Yes
6. Smoke alarms in working order? ☐ No ☐ Yes
7. Use bike helmet? ☐ No ☐ Yes
8. Exercise? ☐ No ☐ Yes, activity level? ______________________________
9. Typical Diet?
   Breakfast: ______________________________
   Lunch: ______________________________
   Dinner: ______________________________
   Snacks:______________________________
10. Sleep Habits: ______________________________
11. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
12. Children? ______________________________
____
13. Intimate relationship positive overall? ☐ Yes ☐ No
14. Sexual Relationship satisfying? ☐ Yes ☐ No
15. Employment: ______________________________
16. Community activities: ______________________________
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17. Hobbies: ______________________________
____
18. Spiritual pursuits: ______________________________
19. Relaxation/meditation: ______________________________

Current Review of System: Please check all that apply to you currently

General:	☐ Fatigue or Change in Energy (too high/too low)	☐ Significant Weight Change *(10 lb wt gain or loss)*	☐ Weakness	☐ Fever
Skin:	☐ Rashes	☐ Lumps	☐ Mole/Freckle Changes	☐ Change in Hair/Nails
HEENT:	☐ Vision Changes	☐ Eye Pain or Redness	☐ Dry/Watery Eyes	☐ Glasses/Contact
	☐ Hearing Aid	☐ Change in Hearing	☐ Ringing in Ears	☐ Vertigo *(Room Spinning)*
	☐ Snoring	☐ Nose Bleeds	☐ Sneezing	☐ Runny/Stuffy Nose
	☐ Hay Fever	☐ Sinus Problems	☐ Bleeding Gums	☐ Dentures
	☐ Sore Tongue	☐ Dry Mouth	☐ Hoarseness	
Neck:	☐ Goiter	☐ Pain/Stiffness	☐ Swollen Glands	
Breasts:	☐ Pain or Discomfort	☐ Lumps	☐ Discharge	
Lungs:	☐ Cough	☐ Coughing up Blood	☐ Wheezing	☐ Shortness of Breath

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CV:	☐ Palpitations	☐ Extra/Skipped Beats	☐ Heart Murmur	☐ Chest Pain
	☐ Need to Sit Upright to Breathe	☐ Shortness of Breath or Coughing that awakes you from sleep	☐	☐ Hx of Clots in legs
	☐ Leg Cramps or Swelling			
GI:	☐ Heartburn	☐ Stomach Pain	☐ Appetite Changes	☐ Nausea
	☐ Constipation or Diarrhea	☐ Bloody or Black Stools	☐ Hemorrhoids	☐ Excessive Gas
GENT:	☐ Frequent Urination	☐ Nighttime urination	☐ Blood in Urine	☐ Loss of Bladder Control
	☐ Infections	☐ Stones	☐ Low Sex Drive	☐ Male: Weak Urine Stream
	☐ Male: Urine Hesitancy	☐ Male: Dribbling	☐ Male: Erectile Dysfunction	☐ Male: Discharge from Penis
	☐ Female: Trouble with Menstration	☐ Female: Vaginal Discharge		
Musculoskeletal:	☐ Joint Pain	☐ Joint Swelling	☐ Muscle Pain	☐ Muscle Cramps
	☐ Back Pain			
Neuro:	☐ Fainting	☐ Blackouts	☐ Seizures	☐ Dizziness
	☐ Numbness	☐ Tingling/Burning Sensations	☐ Headaches	☐ Tremors or Involuntary Movements
Hemo:	☐ Easy Bruising	☐ Easy Bleeding		
Endocrine:	☐ Heat/Cold Intolerance	☐ Excessive Sweating	☐ Excessive Thirst/Hunger	☐ Frequent Urination
	☐ Change in Glove/Shoe Size			