NORTH CLINIC
HEALTH HISTORY QUESTIONNAIRE

Name:_____ Date:_____
Date of Birth:_____ Age:_____
Reason for Today's Visit_____

PAST MEDICAL PROBLEMS

1. List any chronic illness, hospitalizations or surgeries (include dates)

A._____ G._____
B._____ H._____
C._____ I._____
D._____ J._____
E._____ K._____
F._____ L._____

2. Allergies (medications / Latex)

_____
_____

3. Current Medications (Prescription and over the counter)

Name	Strength / Dose	How often taken

FAMILY HISTORY

Please indicate any medical conditions in family members (e.g. diabetes, heart disease, high blood pressure, cancer (breast, colon, other)), lung disease (emphysema, asthma), kidney disease, bleeding tendencies, anemia, arthritis, stroke, glaucoma, migraine headaches, mental illness, etc.

				Age or Age at Death	Medical Illnesses or Causes of Death
Father		deceased	living	_____	_____
Mother		deceased	living	_____	_____
Brothers	(How many?_____)	deceased	living	_____	_____
Sisters	(How many?_____)	deceased	living	_____	_____

Any other family history of illness:_____
_____

RISK FACTORS

1. Do you smoke?..... No Yes
   If yes, how many packs per day?_____ How many years?_____
2. Do you drink alcohol? ……. No Yes
   If yes, how many beverages per day_____ or per week?_____
3. Do you use any other types of recreational drugs?..... No Yes
   If yes, what?_____
4. How many caffeinated beverages do you consume a day?_____
5. Do you exercise?..... No Yes
   If yes, how many times per week?_____ Type of activity?_____
6. Do you wear a seatbelt? If yes, what percentage of the time?_____% No Yes
7. Any family history of diabetes?..... No Yes
   If yes, who?_____
8. Does your family have a history of heart disease or heart attacks before age 60?..... No Yes
   If yes, who and at what age?_____
9. Does your family have any history of cancer?..... No Yes
   If yes, who and what type of cancer?_____
   _____
10. Does your family have a history of osteoporosis or hip fracture?..... No Yes
11. How many servings of milk/dairy/calcium per day? _____
    or amount of calcium/vitamin D supplement taken daily?_____
12. Date of last tetanus booster?_____

GYNECOLOGY HISTORY (women only)

1. When was your last pelvic exam?_____ Your last Pap smear?_____
2. Have you ever had an abnormal Pap smear?_____ When?_____
   If yes, was treatment needed? (circle) No Yes if yes, what type ? freezing cauterizing excision
3. First Day of Last Menstrual period ?_____
4. Are your periods (circle) Regular? Irregular? Painful? Heavy?
5. Have you ever received hormone treatment?..... No Yes
   for birth control?_____ for menopausal symptoms?_____ other?_____
6. Are you sexually active now?..... No Yes
   # of partners in last year_____ last five years_____
7. Current birth control method?_____
8. History of pelvic infections involving the uterus, tubes, or ovaries?_____ No Yes
9. History of sexually transmitted diseases (STD's)_____ No Yes
10. History of endometriosis or infertility?_____ No Yes
11. Date of last mammogram?_____
12. Date of your last bone density test_____ Are you on medication for Osteoporosis?..... No Yes