AdventHealth
Centra Care

Primary Care Services

MEDICAL HEALTH HISTORY QUESTIONNAIRE

Name: _____ **DOB:** _____ **Date:** _____

Information provided on this form will assist your health care provider to better understand your medical conditions and concerns. All questions are optional and will be kept confidential.

Main reason for today's visit: _____

Other Concerns: _____

ALLERGIES **NO KNOWN ALLERGIES** ☐

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1.	
2.	
3.	

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

IMMUNIZATION HISTORY

Immunizations and most recent date:

☐ Flu Shot	Date: _____	☐ Shingles	Date: _____
☐ Tetanus/Diphtheria/Pertussis (DPT)	Date: _____	☐ Pneumonia Vaccine	Date: _____
☐ Chickenpox	Date: _____	☐ Hepatitis A	Date: _____
☐ Measles/Mumps/Rubella (MMR)	Date: _____	☐ Hepatitis B	Date: _____
☐ Human Papillomavirus (HPV)	Date: _____	☐ Haemophilus Influenza Type B (Hib)	Date: _____
☐ Meningitis Vaccine	Date: _____	☐ Td or Tdap	Date: _____

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Age at First Menstrual Cycle _____ Date of Last Menstrual Cycle Date: _____

Age at First Child Birth _____ Date of Last Pap Smear Date: _____ ☐ normal ☐ abnormal

Current Birth Control _____

Date of Last Mammogram Date: _____ Location: _____ ☐ normal ☐ abnormal

If Post-Menopausal, Age at Menopause _____ Post-Menopausal bleeding ☐ yes ☐ no

Hysterectomy ☐ Yes ☐ No Tubal Ligation ☐ Yes ☐ No Cesarean Section ☐ Yes ☐ No

Breast Augmentation ☐ Yes ☐ No Breast Reduction ☐ Yes ☐ No Mastectomy ☐ Yes ☐ No

MEN AND WOMEN

Date of Last Colonoscopy Date: _____ Location: _____ ☐ normal ☐ abnormal

PAST MEDICAL HISTORY

Please check all that apply:

☐ Abnormal Vaginal Bleeding
☐ Acid Reflux (GERD)
☐ Anemia
☐ Asthma
☐ Back Pain
☐ Bladder or Kidney Problems
☐ Cancer
☐ Congestive Heart Failure (CHF)
☐ COPD
☐ Difficulty Sleeping
☐ Dizziness
☐ Dementia/Alzheimers
☐ Depression/Anxiety
☐ Diabetes
☐ DVT/Blood Clot
☐ Epilepsy/Seizures
☐ Headaches/Migraines
☐ Heart Problems
☐ High Blood Pressure (HTN)
☐ High Cholesterol
☐ Kidney Stones
☐ Parkinson's Disease
☐ Recurrent Urinary Tract Infection (UTI)
☐ Sleep Apnea
☐ Thyroid Disease
☐ TIA/Stroke
☐ Other: _____
☐ Other: _____

PATIENT HEALTH QUESTIONNAIRE-2 (PHQ2)

Over the past 2 weeks, how often have you been bothered by any of the following problems:

1. Little interest or pleasure in doing things? ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
2. Feeling down, depressed or hopeless? ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL

SOCIAL HISTORY

Marital Status

☐ Married ☐ Single
☐ Separated ☐ Divorced
☐ Widowed ☐ Domestic Partner

Exercise Level

☐ None (No exercise)
☐ Occasional exercise
☐ Moderate exercise
☐ High level exercise

Tobacco Use

If not currently, did you ever use tobacco? ☐ Yes ☐ No

☐ Cigarettes ____ pks/day
☐ Chew ____ per day
☐ Cigars ____ per day
☐ # of years ____ or year quit _____

Alcohol Use

Do you drink alcohol? ☐ Yes ☐ No
If yes, how often?
Daily ☐ Yes ☐ No
Socially Only ☐ Yes ☐ No
Occasionally ☐ < 3 times a week ☐ > 3 times a week

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	**Y/N**	**____**	☐ **Alcohol abuse** ☐ **Alzheimer's Disease** ☐ **Arthritis** ☐ **Asthma** ☐ **Autism** ☐ **Cancer** ☐ **COPD** ☐ **Depression** ☐ **Diabetes** ☐ **Disorder of Thyroid Gland** ☐ **Heart Disease** ☐ **High Blood Pressure** ☐ **High Cholesterol** ☐ **Obesity** ☐ **Osteoporosis** ☐ **Stroke**
Grandfather (maternal)	**Y/N**	**____**	☐ **Alcohol abuse** ☐ **Alzheimer's Disease** ☐ **Arthritis** ☐ **Asthma** ☐ **Autism** ☐ **Cancer** ☐ **COPD** ☐ **Depression** ☐ **Diabetes** ☐ **Disorder of Thyroid Gland** ☐ **Heart Disease** ☐ **High Blood Pressure** ☐ **High Cholesterol** ☐ **Obesity** ☐ **Osteoporosis** ☐ **Stroke**
Grandmother (paternal)	**Y/N**	**____**	☐ **Alcohol abuse** ☐ **Alzheimer's Disease** ☐ **Arthritis** ☐ **Asthma** ☐ **Autism** ☐ **Cancer** ☐ **COPD** ☐ **Depression** ☐ **Diabetes** ☐ **Disorder of Thyroid Gland** ☐ **Heart Disease** ☐ **High Blood Pressure** ☐ **High Cholesterol** ☐ **Obesity** ☐ **Osteoporosis** ☐ **Stroke**
Grandmother (paternal)	**Y/N**	**____**	☐ **Alcohol abuse** ☐ **Alzheimer's Disease** ☐ **Arthritis** ☐ **Asthma** ☐ **Autism** ☐ **Cancer** ☐ **COPD** ☐ **Depression** ☐ **Diabetes** ☐ **Disorder of Thyroid Gland** ☐ **Heart Disease** ☐ **High Blood Pressure** ☐ **High Cholesterol** ☐ **Obesity** ☐ **Osteoporosis** ☐ **Stroke**
Father	**Y/N**	**____**	☐ **Alcohol abuse** ☐ **Alzheimer's Disease** ☐ **Arthritis** ☐ **Asthma** ☐ **Autism** ☐ **Cancer** ☐ **COPD** ☐ **Depression** ☐ **Diabetes** ☐ **Disorder of Thyroid Gland** ☐ **Heart Disease** ☐ **High Blood Pressure** ☐ **High Cholesterol** ☐ **Obesity** ☐ **Osteoporosis** ☐ **Stroke**
Mother	**Y/N**	**____**	☐ **Alcohol abuse** ☐ **Alzheimer's Disease** ☐ **Arthritis** ☐ **Asthma** ☐ **Autism** ☐ **Cancer** ☐ **COPD** ☐ **Depression** ☐ **Diabetes** ☐ **Disorder of Thyroid Gland** ☐ **Heart Disease** ☐ **High Blood Pressure** ☐ **High Cholesterol** ☐ **Obesity** ☐ **Osteoporosis** ☐ **Stroke**
Brother/Sister	**Y/N**	**____**	☐ **Alcohol abuse** ☐ **Alzheimer's Disease** ☐ **Arthritis** ☐ **Asthma** ☐ **Autism** ☐ **Cancer** ☐ **COPD** ☐ **Depression** ☐ **Diabetes** ☐ **Disorder of Thyroid Gland** ☐ **Heart Disease** ☐ **High Blood Pressure** ☐ **High Cholesterol** ☐ **Obesity** ☐ **Osteoporosis** ☐ **Stroke**
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PREVIOUS PRIMARY CARE PROVIDER

Name of Provider: _____ Phone: _____

Address: _____ Fax: _____

_____

_____

PHARMACY

Pharmacy Name: _____ Phone: _____

Address: _____ Fax: _____

_____

_____

_____ _____

Parent, Guardian, or Caregiver Signature Date

_____ _____

Patient Signature Date