

BASTYR UNIVERSITY

California

Initial Health History Questionnaire

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

Personal Health History		
Name (<i>Last, First, M.I.</i>):	Age:	Sex: DOB:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Number of Children:	Age Range of Children:	
Previous or referring doctor:		
Do you have another primary care provider?		
Reason for visit/goals:		
What are your top 3 expectations of us?		
What behaviors or lifestyle habits do you currently have that you would like to change?		
On a scale of 1-10 (10=highest), how willing are you to make lifestyle changes to achieve better health?:		
List any medical problems that other doctors have diagnosed:		
List all medications and supplements taken regularly		
Name of the Drug or Supplement:	Dose: (strength and frequency)	Prescribed by: (<i>write "self" is self-prescribed</i>)
General Well Being		
Sleep Quality: <input type="checkbox"/> Great <input type="checkbox"/> Good <input type="checkbox"/> Poor		Average number of hours of sleep:
Do you wake feeling rested?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have trouble falling asleep?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wake during the night?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, do you have trouble falling back asleep?		<input type="checkbox"/> Yes <input type="checkbox"/> No
How many colds or flus did you get this year?		
Rate your current energy on a scale of 1-10 (10=highest):		
Rate your current stress level on a scale of 1-10 (10=highest):		
What do you do to manage your stress?		
Do you have a spiritual practice? If so, what?		

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Name:	DOB:	Date:
Health Habits And Personal Safety		
Exercise	In a typical week, how many times do you do the following kinds of exercise for more than 15 minutes :	
	<input type="checkbox"/> Sedentary (No Exercise)	
	Mild Exercise (climb stairs, walk 3 blocks, yoga, golf)	_____ times per week
	Moderate Exercise (fast walking, tennis, dancing)	_____ times per week
	Vigorous Exercise (running, jogging, soccer, long distance bicycling)	_____ times per week
Diet	Do you follow a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify:	
	Do you avoid any foods? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify:	
	How much water do you drink per day? _____ Is it filtered water? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes	
	How many of the last SEVEN DAYS have you followed a healthful eating plan? (circle one)	
	0 1 2 3 4 5 6 7	
	On average, over the past month, how many DAYS PER WEEK have you followed a healthful eating plan?	
	0 1 2 3 4 5 6 7	
	On how many of the last SEVEN DAYS did you eat five or more servings of fruits and vegetables?	
	0 1 2 3 4 5 6 7	
	On how many of the last SEVEN DAYS did you eat high fat foods such as red meat or full fat dairy?	
0 1 2 3 4 5 6 7		
Please list the typical foods and beverages you consume during each meal:		
Breakfast:		
Lunch:		
Dinner:		
Snacks:		
Digestion	How is your digestion? _____ Bowel Movements per week: _____ Well formed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Gas/bloating <input type="checkbox"/> Yes <input type="checkbox"/> No reflux/heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No stomach pain/discomfort <input type="checkbox"/> Yes <input type="checkbox"/> No	
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola/Soda	
	How many cups/cans do you drink per day?	
Drugs	Do you currently use recreational or street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Have you ever used street drugs with a needle? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sex	Are you currently sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Gender of partner(s): <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Other	
	If yes, are you trying for a pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If you are not trying for a pregnancy, list contraceptive or barrier method used:	
	Have you been sexually active in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Gender of past partner(s): <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Other	
Personal Safety	Do you have any problems or concern with sexual function or desire? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health issue. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have frequent falls? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have vision or hearing loss? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you wear your seat belt? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you wear your helmet? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Is the battery current in your smoke detector? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have an Advance Directive or Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Would you like information on the preparation of these? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Physical and/or mental abuse has become a major public health issue. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		

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Name:		DOB:		Date:	
Screening Exams: Please indicate the date of your last exam and whether it was normal. Skip sections that don't apply to your age or health status.				Doctor's Use Only	
Exam		Date	Result	Comments	Date of Review
Weight	Current Weight			BMI: >25 overwt, >30 obese, >40 morbid obese	
	Lowest Adult Weight				
	Highest Adult Weight				
CVD Risk	Cholesterol		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Total: ___ HDL: ___ LDL: ___	Every 5 yrs for M >35yo, F >45 yo	
	Previous heart attack or stroke?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Framingham Risk:	
Diabetes	Fasting Blood Sugar Screening		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Screen: 45yo & BMI > 25; HTN; Lipids	
	Gestational Diabetes		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	HbA1c				
	Average fasting glucose				
	Eye exam		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
Colon Ca	Microalbumin/Creatinine		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
	Colonoscopy		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Every 10 yrs >50 yo	
Women	Hemoccult/ Blood in stool		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Yearly >50 yo	
	Pelvic/Pap Test		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Every 1-3 yrs	
	Mammogram		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Every 1-2 yrs >40	
Men	STI Screening (GC/Chlam)		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	High risk <25	
	PSA		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
	Digital Rectal Exam		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
Additional	STI Screening (GC/Chlam)		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
	HIV Status		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not known	Offer test if u/k status	
	Ophthalmology		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
	Dental		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
	Dermatology		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
Alcohol/Drug Use (CAGE)	DEXA/ Osteoporosis		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
	<i>In the past 2 weeks, have you had any of the following:</i>				
	Little interest or pleasure in doing things?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Feeling down, depressed, or hopeless?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Tobacco	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Do people annoy you by criticizing your use?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Have you felt bad/guilty about your use?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Have you ever had to have an eye opener?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Tobacco	How many cigarettes do you smoke per day?				
	How many years have you smoked?				
	Are you interested in quitting OR What year did you quit?				

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PERSONAL & FAMILY HEALTH HISTORY							Doctor's Use Only	
Please place an "X" in the relevant boxes							Comments	Date of Review:
Condition:	Self	Mother	Father	Sibling	Grandparent (Maternal)	Grandparent (Paternal)		
Alcoholism								
Allergies								
Asthma								
Autoimmune								
Cancer (Specify)								
Depression								
Diabetes								
Eczema								
Heart Disease								
High Cholesterol								
Hypertension								
Mental Illness								
Migraine								
Multiple Sclerosis								
Osteoporosis								
Seizures								
Thyroid								
Other:								
PREVIOUS HOSPITALIZATIONS, SURGERY, OR ACCIDENTS					DATE			
IMMUNIZATIONS/ CHILDHOOD ILLNESSES								
<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps		<input type="checkbox"/> Rubella		<input type="checkbox"/> Chicken Pox			
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Polio		<input type="checkbox"/> Varicella		<input type="checkbox"/> Other			
Immunizations:	<input type="checkbox"/> Tetanus		<input type="checkbox"/> Hepatitis A		<input type="checkbox"/> Hepatitis B			
<input type="checkbox"/> HPV	<input type="checkbox"/> Influenza		<input type="checkbox"/> MMR (Measles, Mumps, Rubella)		<input type="checkbox"/> Pneumonia			
ALLERGIES TO MEDICATIONS								
Name of Drug	Reaction You Had						Comments	Date of Review

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Mental Health		
Is stress a major problem for you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you feel depressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you panic when stressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you cry frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you intentionally harmed yourself or others?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you feel you have an adequate support system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you currently seeing a counselor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
WOMEN ONLY		
Age at onset of menstruation: _____		
First Day of Last Menstrual Period: ___/___/___ Number of days of flow: _____		
Period every _____ Days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of pregnancies _____ Number of Live Births _____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any blood in your urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any problems with control of urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have menstrual, pain, bloating, irritability, or other symptoms at or around the time of your period?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you been instructed on breast self-exams?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
MEN ONLY		
Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, how many times? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any blood in your urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the force of your urine decreased?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any testicle pain or swelling?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you been instructed on testicular self-exams?	<input type="checkbox"/> Yes <input type="checkbox"/> No	