



**UltimateLiving**  
MEDICAL CLINIC

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### HEALTH HISTORY QUESTIONNAIRE FOR INITIAL EXAM

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

Name: \_\_\_\_\_  
*(Last, First, M.I.)*

M  
 F

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Marital

Status:  Single  Partnered  Married  Separated  Divorced  Widowed

Email: \_\_\_\_\_

Date of Last  
Physical Exam: \_\_\_\_\_

### PERSONAL HEALTH HISTORY

Childhood Illness:  Measles  Mumps  Rubella  Chickenpox  Rheumatic Fever  Polio

Immunizations and Dates:	<input type="checkbox"/> Tetanus _____	<input type="checkbox"/> Pneumonia _____
	<input type="checkbox"/> Hepatitis _____	<input type="checkbox"/> Chickenpox _____
	<input type="checkbox"/> Influenza _____	<input type="checkbox"/> MMR _____
		<i>Measles, Mumps, Rubella</i>

List Any Medical Problems That You Have:

Surgeries:

Year	Reason	Hospital
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Other Hospitalizations:

Year	Reason	Hospital
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Have you ever had a blood transfusion? .....  Yes  No

*Please turn to next page*



**All questions contained in this questionnaire are optional and will be kept strictly confidential.**

Sex: Are you sexually active? .....  Yes  No  
 If yes, are you trying for a pregnancy? .....  Yes  No  
 If not trying for a pregnancy list contraceptive or barrier method used? \_\_\_\_\_  
 Any discomfort with intercourse? .....  Yes  No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. 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? .....  Yes  No

Personal Safety: Do you live alone? .....  Yes  No  
 Do you have frequent falls? .....  Yes  No  
 Do you have vision or hearing loss? .....  Yes  No  
 Do you have an Advance Directive and/or Living Will? .....  Yes  No  
 Would you like information on the preparation of these? .....  Yes  No

Physical and/or mental abuse has also become major public health issues in this country. 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? .....  Yes  No

**FAMILY HEALTH HISTORY**

	Age	Age at Death	Significant Health Problems or Cause of Death		Age	Age at Death	Significant Health Problems or Cause of Death
Father				Children	<input type="checkbox"/> M <input type="checkbox"/> F		
Mother					<input type="checkbox"/> M <input type="checkbox"/> F		
Brothers and Sisters	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandparents (Mother's Side)			
	<input type="checkbox"/> M <input type="checkbox"/> F			Male			
	<input type="checkbox"/> M <input type="checkbox"/> F			Female			
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandparents (Father's Side)			
	<input type="checkbox"/> M <input type="checkbox"/> F			Male			
	<input type="checkbox"/> M <input type="checkbox"/> F			Female			

**MENTAL HEALTH**

Is stress a major problem for you? .....  Yes  No  
 Do you feel depressed? .....  Yes  No  
 Do you panic when stressed? .....  Yes  No  
 Do you have problems with eating or your appetite? .....  Yes  No  
 Do you cry frequently? .....  Yes  No  
 Have you ever attempted suicide? .....  Yes  No  
 Have you ever seriously thought about hurting yourself? .....  Yes  No  
 Do you have trouble sleeping? .....  Yes  No  
 Have you ever been to a counselor? .....  Yes  No

### WOMEN ONLY

Age at onset of menstruation: \_\_\_\_\_ Date of last menstruation: \_\_\_\_/\_\_\_\_/\_\_\_\_

Period every \_\_\_\_\_ days. Heavy periods, irregularity, spotting, pain or discharge? .....  Yes  No

Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_

Are you pregnant or breastfeeding? .....  Yes  No

Have you had a D&C, hysterectomy or cesarean?.....  Yes  No

Any urinary tract, bladder or kidney infections within the last year? .....  Yes  No

Any blood in your urine? .....  Yes  No

Any problems with control of urination? .....  Yes  No

Any hot flashes or sweating at night? .....  Yes  No

Difficulty tolerating cold or hot weather? If so, circle which one.....  Yes  No

Any fatigue severe enough to interfere with your daily activities? .....  Yes  No

Do you have menstrual tension, pain, bloating,  
irritability or other symptoms at or around time of period? .....  Yes  No

Experienced any recent breast tenderness, lumps or nipple discharge? .....  Yes  No

Date of last pap and rectal exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of last bone density test: \_\_\_\_/\_\_\_\_/\_\_\_\_

### MEN ONLY

Do you usually get up to urinate during the night? .....  Yes  No If yes, # of times \_\_\_\_\_

Do you feel pain or burning with urination? .....  Yes  No

Any blood in your urine? .....  Yes  No

Do you feel burning discharge from penis? .....  Yes  No

Has the force of your urination decreased? .....  Yes  No

Have you had any kidney, bladder or prostate infections within the last 12 months? .....  Yes  No

Do you have any problems emptying your bladder completely? .....  Yes  No

Any difficulty with erection or ejaculation? .....  Yes  No

Any testicle pain or swelling? .....  Yes  No

Difficulty tolerating cold or hot weather? If so, circle which one.....  Yes  No

Any fatigue severe enough to interfere with your daily activities? .....  Yes  No

Falling asleep often after dinner? .....  Yes  No

Tired more than usual? .....  Yes  No

Sad and/or grumpy? .....  Yes  No

Date of last prostate and rectal exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of last bone density test: \_\_\_\_/\_\_\_\_/\_\_\_\_

### OTHER PROBLEMS

**Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.**

<input type="checkbox"/> Skin _____ <input type="checkbox"/> Head/Neck _____ <input type="checkbox"/> Ears _____ <input type="checkbox"/> Nose _____ <input type="checkbox"/> Throat _____ <input type="checkbox"/> Lungs _____ <input type="checkbox"/> Chest/Heart _____	<input type="checkbox"/> Back _____ <input type="checkbox"/> Intestinal _____ <input type="checkbox"/> Bladder _____ <input type="checkbox"/> Bowel _____ <input type="checkbox"/> Circulation _____ Recent Changes In: <input type="checkbox"/> Weight _____	<input type="checkbox"/> Energy Level _____ <input type="checkbox"/> Ability to Sleep _____ Other Pain/Discomfort: _____ _____ _____
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