Clear Lake Medical Group
Health History Questionnaire

Name (First Last):		Today's Date:	
DOB: ☐ Male ☐ Female		Height:	Weight:
Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Children? ☐ Yes ☐ No If yes, how many? _____			
When was your last flu vaccine?_____ When was your last pneumonia vaccine?			
Occupation: ☐ Retired ☐ Disabled ☐ Working, Current occupation _____			
Primary Care Physician:		Other Provider(s):	
Reason for today's visit:			

PERSONAL HEALTH HISTORY

Past Illness/Injury History: (Diabetes, Hypertension, etc…)

Year	Description

Past Surgical History:

Year	Reason (example: appendectomy)	Location (example: Medical City)

Other Hospitalizations:

Year	Reason	Location

HEALTH HABITS

Alcohol	Do you drink alcohol? ☐ Yes ☐ No If yes, how many glasses a week?_____What type of alcohol? _____
Tobacco	Do you use tobacco? ☐ Yes ☐ Never ☐ No, quit / year _____ If yes, check all that apply: ☐ Cigarettes / # a day_____☐ Chew /_____times a day ☐ Pipe /_____times a day ☐ Cigars / # a day _____

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PERSONAL SAFETY
Do you live alone? ☐ Yes ☐ No Do you use a cane? ☐ Yes ☐ No Do you have frequent falls? ☐ Yes ☐ No Do you use a wheelchair? ☐ Yes ☐ No Do you have an Advanced Directive or Living Will? ☐ Yes ☐ No If no, if you would like one to prepare, please notify the staff.

PLEASE CIRCLE ALL THAT APPLY TO YOUR HEALTH CARE PAST OR PRESENT

CONSTITUTIONAL

Weight Gain
Weight Loss
Night Sweats
Insomnia
Chills / Fever

CARDIO AND VASCULAR

High Blood Pressure
Rheumatic Fever
Heart Murmur
Carotid Disease
Bypass Surgery
Syncope/Fainting
Swelling in feet
Chest Pain or Angina
Heart Attack
Palpitations
Pacemaker
Defibrillator
Atrial Fibrillation

NEUROLOGICAL

Numbness
Weakness
Stroke
Memory Loss
Headaches / Migraines
Balance problems
Blackouts
Inability to concentrate

MUSCULOSKELETAL

Leg / Arm Pain
Leg / Arm Weakness
Osteoarthritis
Rheumatoid Arthritis

RESPIRATORY

Shortness of Breath
Asthma / Wheezing
Sleep Apnea
Snoring
Trouble breathing at night
Coughing up blood
COPD
TB / Tuberculosis
Pneumonia

EYES

Double Vision
Visual Loss or Changes

EAR, NOSE, THROAT AND MOUTH

Hearing Loss
Noise / Ringing in Ears
Drainage from Ears
Nasal Congestion
Nasal Drainage
Inability to Smell
Sore Throat
Trouble Swallowing
Hoarseness
Vertigo / Dizziness

ENDOCRINE

Diabetes
Thyroid Disease
Other: _____

PSYCHIARTIC

Depression
Other _____

ALLERGIC / IMMUNOLOGIC

Sneezing
Itching Eyes
Itchy Throat
Skin Rash
HIV

GASTROINTESTINAL

Abdominal Pain
Blood in Stool
Black Tarry Stool
Bowel Incontinence
Hepatitis
Acid Reflux / Heartburn
Jaundice
Liver Trouble
Ulcer
Nausea / Vomiting

GENITOURINARY

Urinary Incontinence
Bladder Trouble
Blood in Urine
Kidney Disease
Prostate Disease
Sexual Dysfunction

HEMOTOLOGICAL

Bleeding Disorder
Easy Bleeding
Other _____

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FAMILY HEALTH HISTORY							
	Age	Health Problems	Age at Death		Age	Health Problems	Age at Death
Father				Paternal Grandfather			
Mother				Paternal Grandmother			
Sibling(s)				Maternal Grandfather			
Children				Maternal Grandmother			

ALLERGIES	
Have you ever had a problem / reaction with anesthesia? ☐ Yes ☐ No If yes, please explain:	
Are you allergic to any medications? ☐ Yes ☐ No If yes, please list allergy and reaction below	
Allergy/Medication	Reaction

Enter your medications below (include over the counter medications, vitamins, supplements, and Aspirin) or attach your medication list.

MEDICATIONS			
Name	**Dose/Strength**	**Frequency**	**Prescribing Physician**