Date:

VICTOR ARBOLEDA MD, PA

HEALTH HISTORY QUESTIONNAIRE

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

Name: ☐ **M**

(Last, First, M.I.) ☐ **F** **DOB**

Marital Status

☐ **Single** ☐ **Partnered** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Previous or Referring doctor: **Date of Last Physical Exam:**

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ **Measles** ☐ **Mumps** ☐ **Rubella** ☐ **Chicken pox** ☐ **Rheumatic Fever** ☐ **Polio**

Immunizations and Dates:	☐ **Tetanus**	☐ **Pneumonia**
	☐ **Hepatitis**	☐ **Chicken Pox**
	☐ **Influenza**	☐ **MMR** ***(Measles, Mumps, Rubella)***

List any Medical Problems That Other Doctors Have Diagnosed:

Surgeries (Please include years):

Hospitalizations in the last 12 months

Have you ever had a Blood transfusion? ☐ **Yes** ☐ **No**

List your Prescribed Drugs and Over the Counter Drugs, such as vitamins and Inhalers:

Name of Drug/Dose

Allergies to Medications:

Name of Drug	**Reaction you had**

HEALTH HABITS AND PERSONAL SAFETY

Exercise: ☐ Sedentary (No exercise) ☐ Mild Exercise
☐ Occasional Vigorous Exercise (less than 4x/wk for 30 min) ☐ Regular vigorous exercise (4x/wk for 30 min)

Diet:	**Are you dieting?**	☐ Yes ☐ No
	Salt Intake	☐ Hi ☐ Med ☐ Low

Caffeine: ☐ None ☐ Coffee ☐ Tea ☐ Cola
# of cups/cans per day?

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

Alcohol:	**Do you drink alcohol?**	☐ Yes ☐ No
	If yes, what kind? ___________________ How many drinks per week? __________	
	Are you concerned about the amount you drink?	☐ Yes ☐ No
	Have you considered stopping?	☐ Yes ☐ No
	Have you ever experienced blackouts?	☐ Yes ☐ No
	Are you prone to "binge" drinking?	☐ Yes ☐ No
	Do you drive after drinking?	☐ Yes ☐ No
Tobacco:	**Do you use tobacco?**	☐ Yes ☐ No
	Cigarettes – Packs/day___________ # of Years_________________ Or Year Quit _________.	
Drugs:	**Do you currently use recreational or street drugs?**	☐ Yes ☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes ☐ No

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

Sex:	**Are you sexually active?**	☐ 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 a major public health issue 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

Please remember that the following recommendations are very important to maintaining your health:
When in a car, wear your seatbelt at all times.
While riding a motorcycle or bicycle, wear a helmet.
Always have functional smoke detectors and fire extinguishers at home.
If you own a firearm, make sure that it is accessible only to you.
Take every precaution to ensure that children do not have access to a loaded firearm.
Keep the firearm and ammunition in separate locations.

FAMILY HEALTH HISTORY

	Age	Health Problem (or cause of Death)
Father	________	________________________________
Mother	________	________________________________
Siblings	________	________________________________
Children	________	________________________________
Grandparents	________	________________________________

MENTAL HEALTH

During the past month, have you felt down, depressed or hopeless?	☐Yes ☐No
Have you felt little interest or pleasure in doing things?	☐Yes ☐No
Have you ever seriously thought about hurting yourself?	☐Yes ☐No

WOMEN ONLY

Age at onset of menstruation: _______ Date of last menstruation: ___________ Periods occur 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
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐Yes ☐No
Date of last pap smear and rectal exam	/ /
	mm dd yyyy

MEN ONLY

Do you usually get up to urinate during the night?	☐Yes ☐No
	If Yes, # of times
Do you any problem emptying your bladder completely?	☐Yes ☐No
Any difficulty with erection or ejaculation?	☐Yes ☐No
Any testicle pain or swelling?	☐Yes ☐No
Date of last prostate and rectal exam?	/ /
	mm dd yyyy