



# Health History Questionnaire

MARTIN'S POINT  
HEALTH CARE

Thank you for choosing Martin's Point to be your partner in health. To help us give you the highest-quality care, please answer the questions on this form as well as you can. Please bring the completed form with you to your appointment. Your provider may ask some follow-up questions when entering this information into your medical record.

If you are unsure of an answer, please write in a question mark ("?"). If the question does not apply to you, please write in "N/A." You may also add more information in the margins, if needed. Thank you!

## Patient Information

**Last name:** \_\_\_\_\_ **Middle:** \_\_\_\_\_ **First name:** \_\_\_\_\_

**Preferred name:** \_\_\_\_\_ **Sex assigned at birth** (See Gender Identity section for additional options): \_\_\_\_\_

**Date of birth:**     /     /     **Social Security number:** \_\_\_\_\_

**Address:** Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Phone numbers:** Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

**Email address:** \_\_\_\_\_

**How do you prefer we contact you?**     Home phone     Work phone     Mobile phone     Mail

**Usual provider:** \_\_\_\_\_

**Language:** \_\_\_\_\_ **Race:** \_\_\_\_\_ **Ethnicity:** \_\_\_\_\_ Refused  
*(Examples: White, Black or African American, Asian, etc.)*     *(Examples: French, Italian, Mexican, Puerto Rican, Chinese, etc.)*

**How did you hear about us?**     Advertising     Primary care physician     Specialist physician  
Word of mouth     Patient in practice     Hospital  
Insurance company     Other (specify): \_\_\_\_\_

## Medications and Allergies

**Are you currently taking any prescribed or over-the-counter medication(s)?**

No

Yes

(If yes, please list your medication information below—or bring your medication list to your appointment.)

Medication name:	Dose (mg):	How do you take your medication?		Date Started:
1		By mouth	Other	
2		By mouth	Other	
3		By mouth	Other	
4		By mouth	Other	
5		By mouth	Other	
6		By mouth	Other	
7		By mouth	Other	
8		By mouth	Other	
9		By mouth	Other	
10		By mouth	Other	

**Do you have any allergies?**                      No              Yes

(If yes, please list allergy information below.)

<b>Allergy:</b>	<b>Last time you had a reaction? Date:</b>	<b>Symptom(s) experienced:</b>
1		
2		
3		
4		
5		
6		

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## **Social History**

### **Diet and Exercise**

<b>What type of diet are you following?</b>	Regular	Vegetarian	Vegan	Gluten-free	Carbohydrate
	Cardiac	Diabetic	Specific		

<b>What is your exercise level?</b>	Occasional	Moderate	Heavy
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**How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days?**

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**What types of sporting activities do you participate in?**

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**Hobbies/ activities:**

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## Activities of Daily Living

**Are you blind or do you have difficulty seeing?** No Yes

**Are you deaf or do you have serious difficulty hearing?** No Yes

**Do you have difficulty concentrating, remembering, or making decisions?** No Yes

**Do you have difficulty walking or climbing stairs?** No Yes

**Do you have difficulty dressing or bathing?** No Yes

**Do you have difficulty doing errands alone?** No Yes

## Marriage and Sexuality

**What is your relationship status?** Married Single Divorced Separated  
Widowed Domestic Partner Other

**Are you sexually active?** No Yes

**Do you use protection during sex?** Always Usually Never  
(Example: condoms or dams)

**How many children do you have?**

## Home and Environment

**Have there been any changes to your family or social situation?** No Yes

**Do you have smoke and carbon monoxide detectors in your home?** No Yes

**Are you passively exposed to smoke?** No Yes

**Are there any guns present in your home?** No Yes

**What is the fluoride status of your home?** Flouridated Non-Flouridated Unknown

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**Do you use insect repellent routinely?** No      Yes

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**Do you use sunscreen routinely?** No      Yes

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**Substance Use**

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**Do you or have you ever smoked tobacco?** Never smoked Former smoker Currently smoke every day  
Currently smoke some days

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**If yes:      How many years have you smoked tobacco?**  
**At what age did you start smoking tobacco?**

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**Do you or have you ever used any other forms of tobacco or nicotine?** No      Yes

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**Do you or have you ever used e-cigarettes or vape?** Never Former User Current User

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**What is your level of alcohol consumption?** None Occasional  
*Women: Less than 1 drink a day  
Men: Less than 2 drinks a day*  
Moderate  
*Women: 1 drink a day  
Men: 2 drinks a day* Heavy  
*All: 5+ drinks on same occasion,  
at least 5 times in the last month*

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**Do you use any illicit or recreational drugs?** No Yes

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**If yes:      Which illicit or recreational drugs have you used?**  
**How many years have you used illicit or recreational drugs?**

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**Caffeine intake:** None Occasional  
*Less than 1 caffeinated drink a day*  
Moderate  
*1-2 caffeinated drinks a day* Heavy  
*More than 2 caffeinated drinks a day*

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**Public Health and Travel**

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**Have you been to an area known to be high risk for COVID-19?** No      Yes

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**In the 14 days before symptom onset, have you had close contact with a laboratory-confirmed COVID-19 while that case was ill?** No  Yes

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**In the 14 days before symptom onset, have you had close contact with a person who is under investigation for COVID-19 while that person was ill?** No  Yes

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**Lifestyle**

**Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night)?**

Not at all  Only a little  To some extent  Rather much  Very much

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**Do you use your seat belt or car seat routinely?** No  Yes

**Education and Occupation**

**What is the *highest grade or level of school you have completed* or the *highest degree you have received*?**

- Never attended/kindergarten only  Less than Grade 8  Grade 8  Grade 9
  - Grade 10  Grade 11  Grade 12, no diploma
  - GED or equivalent  High school graduate  Some college, no degree
  - Associate degree: occupational, technical, or vocational program
  - Associate degree: academic program
  - Bachelor's degree (e.g., BA, BS, etc.)  Master's degree (e.g., MA, MS, MBA, etc.)
  - Professional school degree (e.g., MD, DDS, etc.)  Doctoral degree (e.g., PhD, etc.)
  - Don't know
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**Occupation:**

**Advanced Directive:**

**Do you have an advanced directive?** No  Yes

**Medical Wellness Visit/IPPE:**

**How confident are you that you can manage most of your health problems?**

Very confident  Somewhat confident  Not very confident

I don't have any health problems

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## Gender Identity and LGBTQ Identity:

**Gender identity:**            Male            Female  
    Transgender Male/Female-to-Male (FTM)  
    Transgender Female/Male-to-Female (MTF)  
    Gender non-conforming (neither exclusively male or female)  
    Other, please specify:

**Assigned sex at birth:**            Male            Female

**Pronouns:**            He/him            She/her            They/them

**First name used:**

**Sexual orientation:**            Lesbian, gay, or homosexual            Straight or heterosexual  
    Bisexual            Other, please describe:  
    Don't know  
    Choose not to disclose

## Family History

**Do any of your biological family members have any diseases/conditions?**            No            Yes

(If yes, list disease(s)/condition(s) information below.)

Check disease (if applicable):	Relation to patient:	Age of family member when disease began:	If disease was terminal, age of family member at time of death:
Alcoholism			
Alzheimer's disease			
Asthma			
Stroke			

Check disease (if applicable):	Relation to patient:	Age of family member when disease began:	If disease was terminal, age of family member at time of death:
COPD			
Coronary artery disease			
Dementia			
Diabetes			
Disorder of endocrine system			
Glaucoma			
High cholesterol			
High blood pressure			
Kidney disease			
Melanoma			
Breast cancer			
Colon cancer			
Lung cancer			



# Surgical History

**Have you had any previous surgeries?**      No      Yes

(If yes, list surgery information below.)

## Check surgery (if applicable):

Ablation (cardiac)	Ear/myringotomy tube placement	Other
Ablation (endometrial)	Eye surgery	Pacer/AICD placement
Ablation (venous)	Frenulectomy	Prostate surgery
Amputation	Bariatric surgery	Prostatectomy
Appendectomy	Gastric surgery	Pyloric stenosis repair
Arthroscopic surgery	Gastrostomy tube replacement	Reconstructive surgery
Back surgery	Joint replacement	Rhinoplasty
Breast augmentation	Knee surgery	Septoplasty
Coronary angioplasty	LEEP	Splenectomy
Coronary angioplasty with stent	Labial adhesions surgery	Strabismus surgery
Cataract surgery	Lumpectomy	Thyroid surgery
Cesarean section	Mastectomy (complete)	Tonsils/adenoid
Gall bladder surgery	Mastectomy (partial)	Tracheostomy
Circumcision	Neck surgery	Tubal ligation
Cleft palate/lip repair	Neurosurgery	Undescended testicle surgery
Colposcopy	Nissen fundoplication	VP shunt placement
Coronary artery bypass (CABG)	Oophorectomy	Valve replacement
D & C	Orthopaedic surgery	Vasectomy

## Past Medical History

**Have you had any past medical issues or conditions?**      No      Yes

(If yes, list any past medical issue or condition information below.)

### Check medical issue/condition (if applicable):

ADD/ADHD	Depression	Kidney disease/failure
Acne	Diabetes type 1	Kidney stones
Alcohol/drug abuse	Diabetes type 2	Liver disease
Allergy (hay fever)	Diverticulosis	MRSA infection
Anemia	Emphysema/COPD	Osteoporosis
Anxiety	Fractures (broken bones)	Pneumonia
Arthritis (osteoarthritis)	GERD/heartburn	Prostate enlargement
Arthritis (rheumatoid)	Gallbladder disease	Recurrent ear infections
Asthma	Glaucoma	Seizure/epilepsy
Autism	Gout	Skin condition (abnormal moles)
Blood clot (leg)	Gynecological condition (endometriosis)	Skin condition (eczema)
Blood clot (lung)	Gynecological condition (fibroids)	Skin condition (psoriasis)
Blood transfusion	Gynecological condition (other)	Sleep apnea
Breast lump (benign)	Headaches	Stomach ulcer
Cancer (breast)	Heart murmur	Stool incontinence
Cancer (cervical)	Hepatitis (other)	Stroke
Cancer (colon)	Hepatitis B	Thyroid (hyper)
Cancer (other type)	Hepatitis C	Thyroid (hypo)
Cancer (ovarian)	High blood pressure	Thyroid (nodule)
Cancer (skin)	High cholesterol	Urinary tract infections (UTI)
Colon polyp	Hip fracture	Urinary (frequency)
Concussion	Irritable bowel syndrome	Urinary incontinence
Constipation		
Coronary artery disease		