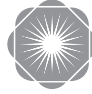
Health History Questionnaire



MARTIN'S POINT®
HEALTHCARE

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!

Last name:		**Middle:**	**First name:**	
Preferred name:		**Gender:**		
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:** *(Examples: White, Black or African American, Asian, etc.)*	**Ethnicity:** *(Examples: French, Italian, Mexican, Puerto Rican, Chinese, etc.)*	Refused	
Marital status:	Married	Single	Divorced	Separated

Widowed

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

Are you currently taking any prescribed or over-the-counter medication(s)? No Yes

(If yes, please list your medication information below.)

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	
11		By mouth	Other	
12		By mouth	Other	
13		By mouth	Other	
14		By mouth	Other	
15		By mouth	Other	

Do you have any allergies? No Yes

(If yes, please list allergy information below.)

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

Advanced Directive: No Yes

Occupation:

Education: Less than Grade 8 Grade 8 Grade 9 Grade 10 Grade 11 Grade 12

College, 2-year College, 4-year Post-graduate

Do you live alone or with others? Alone With others

Number of children:

Diet: Regular Vegetarian Vegan Gluten-free Carbohydrate Cardiac Diabetic Specific

Exercise level: Low Medium High

General stress level:	Low	Medium	High	
Sporting activities:				
Hobbies/ activities:				
Smoking status:	Never smoked	Former smoker	Currently smoke every day	
	Currently smoke some days			
Current smoker—how much?	Occasional *(Not every day)*	Moderate *(Less than one pack a day)*	Heavy *(More than one pack a day)*	
Tobacco-chewing history:	None	Once a day	2–4 times a day	times a day
How many years have you used tobacco?				
Alcohol intake:	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*	
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*	
Do you use recreational/illicit drugs?				
Are you sexually active?			No	Yes
How often do you use protection against sexually-transmitted diseases?				
(Example: condoms or dams)		Always	Usually	Never

Do you perform a breast self-exam monthly?	No	Yes
Do you routinely use a seat belt?	No	Yes
Do you currently have a smoke or carbon monoxide detector in your home?	No	Yes
Do you routinely use sunscreen?	No	Yes
Do you routinely use insect repellent?	No	Yes
Are you legally blind in one or both eyes?	No	Yes
Do you have difficulty hearing or are you deaf in one or both ears?	No	Yes
Are there guns in your home?	No	Yes

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			
COPD			
Coronary artery disease			

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:
Dementia			
Diabetes			
Disorder of endocrine system			
Glaucoma			
High cholesterol			
High blood pressure			
Kidney disease			
Melanoma			
Breast cancer			
Colon cancer			
Lung cancer			

Have you had any previous surgeries? ☐ No Yes
(If yes, list surgery information below.)

Check surgery (if applicable):

Ablation (cardiac)

Ablation (endometrial)

Ablation (venous)

Amputation

Appendectomy

Arthroscopic surgery

Back surgery

Breast augmentation

Coronary angioplasty

Coronary angioplasty with stent

Cataract surgery

Check surgery (if applicable):

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

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
- Acne
- Alcohol/drug abuse
- Allergy (hay fever)
- Anemia
- Anxiety
- Arthritis (osteoarthritis)
- Arthritis (rheumatoid)
- Asthma
- Autism
- Blood clot (leg)
- Blood clot (lung)
- Blood transfusion
- Breast lump (benign)
- Cancer (breast)
- Cancer (cervical)
- Cancer (colon)
- Cancer (other type)

Check medical issue/condition (if applicable):

- Cancer (ovarian)
- Cancer (skin)
- Colon polyp
- Concussion
- Constipation
- Coronary artery disease
- Depression
- Diabetes type 1
- Diabetes type 2
- Diverticulosis
- Emphysema/COPD
- Fractures (broken bones)
- GERD/heartburn
- Gallbladder disease
- Glaucoma
- Gout
- Gynecological condition (endometriosis)
- Gynecological condition (fibroids)
- Gynecological condition (other)
- Headaches
- Heart murmur
- Hepatitis (other)
- Hepatitis B
- Hepatitis C
- High blood pressure
- High cholesterol
- Hip fracture
- Irritable bowel syndrome
- Kidney disease/failure
- Kidney stones
- Liver disease
- MRSA infection
- Osteoporosis
- Pneumonia
- Prostate enlargement
- Recurrent ear infections
- Seizure/epilepsy
- Skin condition (abnormal moles)
- Skin condition (eczema)
- Skin condition (psoriasis)
- Sleep apnea
- Stomach ulcer
- Stool incontinence
- Stroke
- Thyroid (hyper)
- Thyroid (hypo)
- Thyroid (nodule)
- Urinary tract infections (UTI)
- Urinary (frequency)
- Urinary incontinence