Washington University in St. Louis Physicians

Welcome!

Washington University Medical Education

Health History Questionnaire

Patient's Name _____ Age _____ Today's Date ___/___/___

Home Phone _____ Cell Phone _____ Work Phone _____

Name of Emergency Contact _____ Phone Number _____ Relationship _____

REASON FOR ESTABLISHING CARE

☐ 1) Problem _____

☐ 2) Prevention Care (annual visit, physical, wellness visit) _____

PAST MEDICAL HISTORY

☐ Abnormal heartbeat	☐ Depression	☐ High blood pressure	☐ Sexual infection
☐ Anemia	☐ Diabetes	☐ High cholesterol	☐ Stroke or TIA
☐ Anxiety	☐ Emphysema	☐ Insomnia	☐ Weight problems
☐ Arthritis	☐ Fatty liver	☐ Irritable bowel syndrome	☐ Thyroid disorder
☐ Asthma	☐ Gallstones	☐ Kidney disease	☐ Other _____
☐ Bladder infection	☐ Glaucoma	☐ Kidney stones	_____
☐ Cancer:	☐ Genital warts	☐ Oral ulcer	_____
(type) _____	☐ Headache– daily or weekly	☐ Osteopenia	
☐ Chronic bronchitis	☐ Heart attack	☐ Osteoporosis	
☐ Dementia	☐ Heartburn	☐ Seasonal allergies	

SURGICAL HISTORY Please list all operations including the approximate year and location

	Type of Surgery	Location	Year		Type of Surgery	Location	Year
1.				6.			
2.				7.			
3.				8.			
4.				9.			
5.				10.			

ALLERGIES

Do you have any allergies to <u>medications</u>? ☐ No ☐ Yes *If yes,* please list _____

_____

_____

_____

Name _____

Date of Birth / /

MEDICATIONS

Please list the current medications you are taking, including herbs, supplements, and over-the-counter.

	Name	Strength	Times/day (frequency)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

PHARMACY INFORMATION

Local Pharmacy _____

Mail Order Pharmacy _____

PREVIOUS CARE CARE PHYSICIAN

My prior primary care physician or medical provider was:

Name_____

Name _____

Date of Birth ____/____/____

LIFESTYLE AND SOCIAL HISTORY

1. Who lives with you? ☐ Spouse/Significant Other ☐ Your Minor Children: Ages_____ ☐ Parent(s) ☐ None
☐ Roommate(s) ☐ Siblings ☐ Your Adult Children ☐ Your Grandchildren ☐ Grandparent(s) ☐ Other _____

2. Do you use tobacco? ☐ Never ☐ Yes ☐ Quit
☐ Cigarettes ☐ Other (specify) _____ _____ per day for_____ years if quit, when?_____

3. Do you drink alcohol? ☐ Never ☐ Quit ☐ Yes *If yes,* answer the following:
How much?_____ per week Drink(s) of choice _____
Have you ever tried to cut down on your drinking? ☐ No ☐ Yes
Have you ever become annoyed at anyone for criticizing your drinking? ☐ No ☐ Yes
Have you ever felt guilt about your drinking? ☐ No ☐ Yes
Have you ever had an early morning drink (eye-opener)? ☐ No ☐ Yes

4. What other substance have you tried or do you currently use?
☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Stimulants ☐ Other _____

5. Have you ever been in a relationship in which you were threatened, hurt, or frightened? ☐ No ☐ Yes

6. What kind of work do you or did you do? _____

7. Do you have a Living Will or Durable Power of Attorney? ☐ No ☐ Yes

8. If you were incapacitated, who should speak for you? _____

FAMILY HISTORY

Please indicate each family member that has been diagnosed with any of the following.

Cancer	☐ mother	☐ father	☐ sibling	☐ child	☐ maternal grandparent	☐ paternal grandparent
Diabetes	☐ mother	☐ father	☐ sibling	☐ child	☐ maternal grandparent	☐ paternal grandparent
High cholesterol	☐ mother	☐ father	☐ sibling	☐ child	☐ maternal grandparent	☐ paternal grandparent
High blood pressure	☐ mother	☐ father	☐ sibling	☐ child	☐ maternal grandparent	☐ paternal grandparent
Heart attack	☐ mother	☐ father	☐ sibling	☐ child	☐ maternal grandparent	☐ paternal grandparent
Obesity	☐ mother	☐ father	☐ sibling	☐ child	☐ maternal grandparent	☐ paternal grandparent
Osteoporosis	☐ mother	☐ father	☐ sibling	☐ child	☐ maternal grandparent	☐ paternal grandparent
Stroke or T.I.A.	☐ mother	☐ father	☐ sibling	☐ child	☐ maternal grandparent	☐ paternal grandparent

REVIEW OF SYSTEMS

General

Unintended weight loss	☐ Yes	☐ No
Unintended weight gain	☐ Yes	☐ No
Fevers	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Swollen lymph glands	☐ Yes	☐ No
Fallen in last month	☐ Yes	☐ No

Respiratory

Shortness of breath with activity	☐ Yes	☐ No
Leg pain with walking	☐ Yes	☐ No
Shortness of breath at night	☐ Yes	☐ No
Snoring	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Sputum/phlegm	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No

Neurologic

(New) problems speaking	☐ Yes	☐ No
(New) memory problems	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Numbness or weakness of arm or leg	☐ Yes	☐ No

Cardiovascular

Chest pain	☐ Yes	☐ No
Irregular heartbeat	☐ Yes	☐ No
Pain, tightness or discomfort in neck	☐ Yes	☐ No
Leg/foot swelling	☐ Yes	☐ No

Psychiatric

Often nervous/anxious	☐ Yes	☐ No
Panic attack	☐ Yes	☐ No
Trouble concentrating	☐ Yes	☐ No
Often unhappy or depressed	☐ Yes	☐ No
Lost interest in activities	☐ Yes	☐ No
Trouble sleeping	☐ Yes	☐ No

Gastrointestinal

Poor appetite	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Red blood in stools	☐ Yes	☐ No
Black, tarry stools	☐ Yes	☐ No
Pain with bowel movements	☐ Yes	☐ No

Eyes/Ears/Nose/Throat

Trouble hearing	☐ Yes	☐ No
Other ear problems	☐ Yes	☐ No
Sinus/nose problems	☐ Yes	☐ No
Trouble seeing	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No
Other eye problems	☐ Yes	☐ No
Hoarseness	☐ Yes	☐ No
Trouble swallowing	☐ Yes	☐ No
Pain in throat	☐ Yes	☐ No

Genitourinary

Pain with urination	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Urinating more than once during night	☐ Yes	☐ No
Trouble holding urine	☐ Yes	☐ No
Trouble starting stream or emptying bladder	☐ Yes	☐ No
Pain with sex	☐ Yes	☐ No
Low libido	☐ Yes	☐ No

Please see other side ▶

WUP MED HLTH QUES 2501 C NL (Rev 06/16)

It is very important for your health that you answer these questions as completely and accurately as you can. If you do not understand something, please ask us for help. We want you to live a healthier life.

Name _____

Date of Birth ____/____/____

REVIEW OF SYMPTOMS Men only

☐ Problems with erections ☐ Testicular lump/pain ☐ Scrotum swelling/pain ☐ Groin pain
☐ Blood in semen ☐ Discharge from penis

REVIEW OF SYMPTOMS Women only

☐ Breast lumps/pain ☐ Vaginal discharge ☐ Vaginal dryness ☐ Hot flashes ☐ Nipple discharge

Do you still have monthly periods? ☐ Yes *If yes,* are they regular? ☐ No ☐ Yes
Days between periods_____ Age at first period_____ Date of last period _____
Are periods heavy? ☐ No ☐ Yes
Are periods painful? ☐ No ☐ Yes *If yes,* how painful? ☐ moderate ☐ severe
☐ No If no, why? ☐ Menopause ☐ Medication (list)_____ ☐ Unknown
Age at menopause_____

Have you ever been pregnant? ☐ No ☐ Yes *If yes,* how many:
Live births_____ Miscarriages____ Stillbirths_____ Abortions____
Any babies born before 37 weeks? ☐ No ☐ Yes
Any babies under 2500 grams (under 5 lbs 8 oz)? ☐ No ☐ Yes
Any history of gestational diabetes? ☐ No ☐ Yes
Any history of high blood pressure in pregnancy? ☐ No ☐ Yes
Any history of pre eclampsia? ☐ No ☐ Yes
Describe any complications _____

Do you use birth control? ☐ No ☐ Yes If yes, check **all** methods you use:
☐ Condoms ☐ IUD (copper) ☐ Sponge ☐ Natural/Rhythm
☐ Patch ☐ Injections ☐ Vaginal (Nuva) Ring ☐ Implant (Nexplanon)
☐ Diaphragm ☐ Oral Contraceptives (the pill) ☐ IUD (hormone)
☐ Spermicide (gel, cream, suppository, foam)
☐ Non-surgical sterilization (Essure)
☐ Surgical sterilization (tubes tied)/or partner with vasectomy

IMMUNIZATION HISTORY Please answer each and give the approximate date for your last shot

Have you been vaccinated for?

Hepatitis A	☐ No ☐ Don't know ☐ Yes *If yes,* year _____	Pneumovax (Pneumonia)	☐ No ☐ Don't know ☐ Yes *If yes,* year _____
Hepatitis B	☐ No ☐ Don't know ☐ Yes *If yes,* year _____	Prevnar (Pneumonia)	☐ No ☐ Don't know ☐ Yes *If yes,* year _____
Measles/Mumps/Rubella	☐ No ☐ Don't know ☐ Yes *If yes,* year _____	Zostavax (Shingles)	☐ No ☐ Don't know ☐ Yes *If yes,* year _____
Tetanus Booster	☐ No ☐ Don't know ☐ Yes *If yes,* year _____	Human Papilloma Virus (HPV)	☐ No ☐ Don't know ☐ Yes *If yes,* year _____
Chicken Pox	☐ No ☐ Don't know ☐ Yes *If yes,* year _____	Flu Shot	☐ No ☐ Don't know ☐ Yes *If yes,* year _____

Your healthcare is very important to us.

Thank you for choosing

Washington University Physicians.

Name _____

Date of Birth / /

SCREENING TESTS Please answer each and give the approximate date for your last test

Have you had the following test(s)?

HIV	☐ No	☐ Don't know	☐ Yes	*If yes,* year _____
	Results:	☐ Normal	☐ Abnormal	*If abnormal,* findings _____
Gonorrhea/Chlamydia	☐ No	☐ Don't know	☐ Yes	*If yes,* year _____
	Results:	☐ Normal	☐ Abnormal	*If abnormal,* findings _____
Pap Smear	☐ No	☐ Don't know	☐ Yes	*If yes,* year _____
	Results:	☐ Normal	☐ Abnormal	*If abnormal,* findings _____
Mammogram	☐ No	☐ Don't know	☐ Yes	*If yes,* year _____
	Results:	☐ Normal	☐ Abnormal	*If abnormal,* findings _____
Hepatitis C	☐ No	☐ Don't know	☐ Yes	*If yes,* year _____
	Results:	☐ Normal	☐ Abnormal	*If abnormal,* findings _____
PSA (for men at high risk of prostate cancer only)	☐ No	☐ Don't know	☐ Yes	*If yes,* year _____
	Results:	☐ Normal	☐ Abnormal	*If abnormal,* findings _____
Colonoscopy (for colon cancer)	☐ No	☐ Don't know	☐ Yes	*If yes,* year _____
	Results:	☐ Normal	☐ Abnormal	*If abnormal,* findings _____
Chest CT (for lung cancer in high risk current or ex-smokers only)	☐ No	☐ Don't know	☐ Yes	*If yes,* year _____
	Results:	☐ Normal	☐ Abnormal	*If abnormal,* findings _____
Bone Density (for osteoporosis)	☐ No	☐ Don't know	☐ Yes	*If yes,* year _____
	Results:	☐ Normal	☐ Abnormal	*If abnormal,* findings _____
Aneurysm screening (men over 65 only)	☐ No	☐ Don't know	☐ Yes	*If yes,* year _____
	Results:	☐ Normal	☐ Abnormal	*If abnormal,* findings _____

Patient's Signature _____ Date _____