MERCED FACULTY ASSOCIATES HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please approximate. Add any notes you think are important. **ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.**

Main reason for today's visit: _____ Other concerns: _____

CURRENT MEDICATIONS – Please list the medications you currently take. If you are not currently taking any medications, please check the "none" box to the right. ☐ **None**
1.
2.
3.
4.
5.
6.
7.
MEDICATION/ALLERGY SENSITIVITY **List all medications allergic to:** ☐ **None**
1.
2.
3.
4.
YOUR PROVIDERS – Please list the doctors you see in the community.
1.
2.
PHARMACIES – list the address and phone number for pharmacies, both local and mail away.
1.
2.

PAST MEDICAL HISTORY - Please check the box if you have had or experienced these symptoms or medical issues. If none, indicate by checking the "none" box to the right. ☐**None**

☐ Abdominal Pain	☐ Developmental or Behavior Disorders	☐ Leg Swelling
☐ ADD or ADHD	☐ Diabetes	☐ Liver Disease
☐ Allergies, Seasonal	☐ DVT's / Pulmonary Embolism	☐ Loss of Memory/Consciousness
☐ Anemia	☐ Ear or Hearing Problems	☐ Lung Disease/Pneumonia
☐ Anesthesia Complications	☐ Excessive Thirst	☐ Mental Illness
☐ Anxiety Disorder	☐ Fatigue	☐ Muscle, Joint, or Bone Problems
☐ Arthritis	☐ Gout	☐ Osteoporosis
☐ Asthma	☐ Headaches	☐ Seizures/Epilepsy
☐ Birth Defects or Inherited Disease	☐ Heat or Cold Intolerance	☐ Sexual Problems
☐ Bladder or Kidney Problems	☐ Heart Disease	☐ Shortness of breath
☐ Bleeding Tendency	☐ Heart Murmur	☐ Skin Problems
☐ Blood in Stool	☐ Heart Palpitation	☐ Stroke/TIA
☐ Blood Transfusions	☐ Hepatitis	☐ Suicidal Thoughts
☐ Cancer	☐ High Blood Pressure	☐ Thyroid Problems
☐ Chest Pain	☐ High Cholesterol	☐ Traumatic Illness or Injuries
☐ Chicken Pox	☐ Hospital Admission other than birth	☐ Tuberculosis
☐ Constant Fever/Chills	☐ Hurt Other People	☐ Ulcer/Other GI Problems
☐ Constipation	☐ Incontinence	☐ Valley Fever
☐ Depression	☐ Kidney Disease	☐ Vision or Eye Problems

PAST HEALTH MAINTENANCE - Please check the box if you have recently completed these tests. For those completed, list date of test in (MM/YYYY) format and if the result was normal or abnormal.		
Test Name	Date	Result
☐ Bone Density Scan		
☐ Cholesterol Panel		
☐ Colonoscopy		
☐ Mammography		
☐ Pap		
☐ PSA		

FAMILY HISTORY ☐ **None**		
☐ Alcohol/Substance Abuse	☐ Diabetes	☐ Neurologic Problems
☐ Allergies, Seasonal	☐ Epilepsy/Seizures	☐ Obesity
☐ Anxiety Disorder	☐ Headaches/Migraines	☐ Osteoporosis
☐ Asthma	☐ Heart Problem	☐ Other
☐ Bleeding Disorders	☐ High Cholesterol	☐ Psychiatric Problems
☐ Cancer	☐ Hypertension	☐ Rheumatoid Arthritis
☐ COPD	☐ Immune Problems	☐ Stroke
☐ Dementia	☐ Kidney Disease	☐ Thyroid Problems
☐ Depression	☐ Liver Problems	☐ Tuberculosis
☐ Developmental Disorders	☐ Lung Cancer	

SOCIAL HISTORY/LIFESTYLE	
Occupation:	Caffeine Intake (None/Occasional/Moderate/Heavy):
Education Level:	Chewing Tobacco
Marital Status:	Illicit Drugs:
Sexual Orientation:	Sexually Active?
Exercise Level (Occasional/Moderate/Heavy):	Seatbelts used routinely?
Diet (Regular/Vegetarian/etc.):	Sunscreen used routinely?
General Stress Level (Low/Medium/High):	Smoke alarm in home?
Smoking Status (Never/Former/etc.):	Advance directive?
Smoking (How much per day/week?):	*Racial or cultural identity:*
Has smoked since age?	Religious preference:
Alcohol Intake (None/Occasional/Moderate/Heavy):	

SURGICAL PROCEDURES ☐ **More than four**		
Month/Year	Illness/Operation	Complication (Y/N)

GYN & PREGNANCY HISTORY ***(FEMALES ONLY)***	
Currently Pregnant (Y/N):	Frequency of Cycle (Days):
How many times have you been pregnant?	Flow (Light/Moderate/Heavy):
How many vaginal deliveries have you had?	Duration of Flow (Days):
How many cesarean sections have you had?	Menses Monthly (Y/N):
How many miscarriages have you had?	Age at First Child:
How many pregnancy terminations (if any) have you had?	Age at Menarche:
Have you used any of the following birth control methods in the past? Birth Control Pills/ IUD's/ Depo-Provera Injections	Current Birth Control Method: On BCP's at Conception
Date of LMP:	If postmenopausal, age at menopause:

To my understanding, this represents an accurate portrayal of my health history. I will inform Merced Faculty Associates as changes or updates occur.

_____

Patient Signature Date