De Lucia Advance Practice
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Health History Questionnaire

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

Name: *(Last, First, M.I.):*	**Highest Level of Education:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Other_____ ☐ **Denies**

Immunizations and dates:		
	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed: ☐ **Denies**

Heart Attack/MI	☐ yes ☐ no	Elevated Cholesterol	☐ yes ☐ no	Depression	☐ yes ☐ no
High Blood Pressure	☐ yes ☐ no	Heart Murmur	☐ yes ☐ no	Anxiety	☐ yes ☐ no
Stroke/CVA	☐ yes ☐ no	Anemia	☐ yes ☐ no	PTSD	☐ yes ☐ no
Asthma/COPD	☐ yes ☐ no	HIV/AIDS	☐ yes ☐ no	Reflux/GERD	☐ yes ☐ no
Diabetes	☐ yes ☐ no	Hepatitis:_____	☐ yes ☐ no	Thyroid Disease	☐ yes ☐ no
Epilepsy/Seizures	☐ yes ☐ no	DVT/PE	☐ yes ☐ no	Sexually Transmitted Disease	☐ yes ☐ no
Cancer:_____	☐ yes ☐ no	Glaucoma	☐ yes ☐ no	HIV/AIDS	☐ yes ☐ no
Kidney Disease	☐ yes ☐ no	Arthritis	☐ yes ☐ no	Emphysema/Bronchitis	☐ yes ☐ no
Liver Disease	☐ yes ☐ no	Congestive Heart Failure	☐ yes ☐ no	Kidney Stones	☐ yes ☐ no
Pneumonia	☐ yes ☐ no	Sinusitis	☐ yes ☐ no	Other:_____	☐ yes ☐ no

Surgeries ☐ **Denies**

Year	Reason	Hospital

Other hospitalizations ☐ **Denies**

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers: ☐ **Denies**

Name the Drug:	**Strength:**	**Frequency Taken**:

NAME_____ DATE_____

Allergies to medications:				☐ **Denies**
Name the Drug	**Reaction You Had**:			

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol on a regular basis?				☐ 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 – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational/street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	Sexual Preference: ☐ men ☐ women ☐ both					
	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 or Living Will?				☐ Yes	☐ No
	Would you like information on the preparation of these?				☐ Yes	☐ No
	Physical and/or mental abuse has also become major public health issues 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

NAME_____ DATE_____

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
If yes how many hours of uninterrupted sleep do you get a night?		
Have you ever been to a counselor/psychiatrist?	☐ Yes	☐ No

OTHER PROBLEMS

Check the box if you have, or have had any of the following symptoms:

☐ Visual Changes/Loss	☐ Shortness of breath	☐ Changes in muscle strength/Weakness
☐ Dizziness	☐ Persistent Cough	☐ Swelling:_____
☐ Head Injury	☐ Numbness	☐ Falling
☐ Headaches/Migraines	☐ Pins/Needles Sensation	☐ Emotionally Abused
☐ Palpitations	☐ Rash/Skin Disorder	☐ Physically Abused
☐ Night Sweats/Fever	☐ Ulcers	☐ Sexually Abused
☐ Heartburn	☐ Pneumonia	☐ Chronic Fatigue
☐ Hearing Loss	☐ Constipation/Diarrhea	☐ Tremors
☐ Sleep Apnea	☐ Difficulty controlling bowel or bladder	☐ Mental Illness
☐ Blood Clots	☐ Chills	☐ Memory problems
☐ GYN (female) problems	☐ Cancer/Tumors/Cysts	☐ Difficulty with sleep
☐ Allergies	☐ Back Pain	☐ Childhood Illness:_____
☐ Recent Weight Changes	☐ Other pain:	☐ Other chronic health issues: _____

PROVIDER'S COMMENTS

NAME_____ DATE_____