Adena Family Medicine- Ironmen Clinic

Health History Questionnaire

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

Patient/Student Name:_____**DOB:**_____

Current Family Medicine Provider/Pediatrician:_____

Date of last exam:_____

Would you like a Comprehensive Wellness Exam Performed □ Yes □ No

**Insurance companies, including Medicaid, pay for an annual wellness exam, at no expense to you*

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

**Attach additional page if necessary*

Name of Medication	Strength/Dosage	Frequency Taken

Medical History *Please check all that apply.*

Heart Problems	Never Had	Have Now	Had in the Past
Irregular Heart Beat (arrhythmias)			
Heart Failure			
High Blood Pressure			
Other, Specify			

Lung Problems	Never Had	Have Now	Had in the Past
Asthma			
Bronchitis			
Other, Specify			

Bone & Joint Problems	Never Had	Have Now	Had in the Past
Arthritis			
Fracture of the Hip, Wrist, Spine, Arm, Leg (circle which one)			
Other, Specify			

Gland Problems	Never Had	Have Now	Had in the Past
Diabetes			
Thyroid, Overactive (High)			
Thyroid, Underactive (Low)			
Other, Specify			

ENT	Never Had	Have Now	Had in the Past
Chronic Allergies			
Congestion			
Difficulty Swallowing			
Other, Specify			

Kidney and Urinary Problems	Never Had	Have Now	Had in the Past
Kidney Disease			
Frequent Bladder or Kidney Infections			
Urinary Incontinence (wetting)			
Other, Specify			

GI Problems	Never Had	Have Now	Had in the Past
Chronic Constipation			
Diarrhea			
Indigestion			
Vomiting			
Chronic Abdominal Pain			
Other, Specify			

Mental/Behavioral Health Problems	Never Had	Have Now	Had in the Past
Anxiety			
Depression			
Learning Disabilities			
Other, Specify			

Eyes: □ Wears Glasses □ Contacts □ Vision Changes

Date when vision changes occurred_____

Allergies to Medications

Name of the Medication	Reaction you had

Surgical History

Year	Reason/Diagnosis	Hospital

Hospitalizations

Year	Reason/Diagnosis	Hospital

Childhood Illnesses: □ Measles □ Mumps □ Rubella □ Chicken Pox □ Rheumatic Fever □ Polio

Family History of Illnesses (mark those that apply):

	No History	Mental Health	Diabetes	Heart Disease	Hypertension	COPD	Asthma	Cancer
Mother								
Father								
Brother								
Sister								
Grandmother								
Grandfather								

Women Only

Age at onset of menstruation:_____Date of last menstruation:_____Period every ___days

Heavy periods, irregularity, spotting, pain, or discharge? □ Yes □ No

Number of pregnancies _____ Number of live births _____

Are you pregnant or breastfeeding? □ Yes □ No Date of last pap smear:_____

Men Only

Do you usually get up to urinate during the night? Yes No If yes, # of times _____

Do you feel pain or burning with urination? □ Yes □ No Any blood in your urine? □ Yes □ No

Do you feel burning discharge from penis? □ Yes □ No

Do you have any problems emptying your bladder completely? □ Yes □ No

Any testicle pain or swelling? □ Yes □ No

Please list any medical or behavioral health history that was not specially asked, but that would be pertinent to the student's/patient's care.

1. _____
2. _____
3. _____

_____ _____

Signature of Person Completing this Form **Date**
(Should be completed by parent/legal guardian)