Today's date_____

R-Health New Brunswick
Health History Questionnaire
(please print clearly)

Name: _____Date of Birth: _____

Past Medical History: *(Check all items that apply to you. Write in details below as needed)*

__allergies
__anemia or blood disorders
__arthritis
__asthma
__blood transfusion, year_____
__cancer/tumor, type_____
__chickenpox, year_____
__COPD/emphysema
__diabetes
__drug or alcohol abuse
__epilepsy or seizure
__hearing loss
__heart disease or heart attack
__hepatitis
__HIV/AIDS
__high blood pressure
__kidney disease or stones
__ulcer disease or reflux
__depression/anxiety
__other mental illness
__sexually-transmitted disease
__skin disease, eczema, psoriasis
__stroke
__thyroid disease

Past Medical History Details/Other:

_____

_____

_____

Past Surgical History: *(Please list, including year of procedure)*

_____

_____

_____

Social History:

Marital Status: ❑ Single ❑ Married ❑ Divorced/ Separated ❑ Partnered
With whom do you live? _____
Are you …. ? ___ Employed; type of work_____
___ Disabled: reason / year _____
___ Homemaker ___ Military or former military
___ Retired ___ Student

Habits and Diet:

Do you currently smoke? ❑ No ❑ Yes
Did you smoke in the past? ❑ No ❑ Yes If yes, when did you quit? _____
If you smoke(d) How many packs per day? _____For how many years? _____
Do you drink alcohol? ❑ No ❑ Yes
If yes, how many drinks do you have in a typical day? _____or typical week?_____
Have you used illegal or recreational drugs in the past year? ❑ No ❑ Yes

How many caffeinated beverages do you have per day? _____

Are you on a special diet (vegetarian, gluten free, low salt, Diabetic, etc)? ❑ No ❑ Yes

If yes, specify: _____

On average, how many servings of fruits and vegetables do you consume each day?_____

Do you exercise regularly? ❑ No ❑ Yes (please specify what kind and how often)

_____

Do you use a seatbelt? ❑ No ❑ Yes

Do you wear sunblock when out in the sun for extended periods of time? ❑ No ❑ Yes

Do you use contraception if you are sexually active? ❑ No ❑ Yes ❑ N/A

Do you practice safe sex if you are sexually active? ❑ No ❑ Yes ❑ N/A

New sexual partners within the last year? ❑ No ❑ Yes

Family History:

	Mother	Father	Grandmother or Grandfather	Brother/Sister	Child
Alzheimers					
Asthma					
Arthritis					
Allergies					
Alcoholism					
Blood disorders					
Cancer (specify type)					
Depression/anxiety					
Other mental illness					
Diabetes					
Heart disease					
High blood pressure					
Stomach/intestinal disease					
Stroke					
Skin disease					
Thyroid problem					
Age at death					

Health Maintenance: (*Please list the date that you last had these tests or procedures.)*

When was your last…?

Physical:	❑ Never or Date: _____	Blood work:	❑ Never or Date: _____
Eye Exam:	❑ Never or Date: _____	Dental Exam:	❑ Never or Date: _____
Colonoscopy:	❑ Never or Date: _____	Bone density/DEXA:	❑ Never or Date: _____

Women Only: Pap smear: ❑ Never or Date: _____

Mammogram: ❑ Never or Date: _____

Male Only: PSA: ❑ Never or Date: _____

Other Health Care Providers:

Do you have a…?		**Name and address**
Dentist	❑ No ❑ Yes	_____
Eye doctor	❑ No ❑ Yes	_____
OB/GYN	❑ No ❑ Yes	_____
Gastroenterologist	❑ No ❑ Yes	_____
Cardiologist	❑ No ❑ Yes	_____
Mental Health	❑ No ❑ Yes	_____
Other		_____

Immunizations:

Tetanus (Td or Tdap)	Date _____	Influenza (Flu)	Date _____
Hepatitis B	Date _____	Pneumonia	Date _____
Chicken Pox	Date _____	Gardasil (HPV)	Date _____
Zoster (shingles)	Date _____	Other	Date_____

If you do not know your immunization history, what doctor or office may have immunization records:

Name: _____

Review of Systems: *(**check any of the following that you have or have had in the past 3 months**)*

Skin		**Neurologic**	
	Rashes		Seizures
	Change in a wart or mole		Headache
Eye, Ear Nose and Throat			Numbness or tingling
	Vision changes		Dizziness
	Eye pain		Balance problems
	Nosebleeds	**Digestion**	
	Sinus problems		Heartburn or reflux
	Ear pain		Nausea - persistent
	Hearing loss		Vomiting
	Unusual sore throat		Diarrhea - persistent
	Hoarseness - persistent		Constipation - persistent
	Swollen glands		Abdominal pain
	Tooth pain		Black stool
	Gum or mouth sores or problems		Bloody stools
Respiratory			Jaundice or yellow skin
	Shortness of Breath	**Urinary**	
	Wheezing		Pain on urination
	Cough		Frequent urination
	Coughing blood		Frequent urination at night
Cardiovascular			Inability to hold urine
	Chest pressure		Blood and urine
	Chest pain		Kidney stones
	Irregular heartbeat	**Mental/emotional**	
	Palpitations		Anxiety
	Swelling in ankles/lower legs		Depression
Endocrine			Poor concentration
	Heat Intolerance		Poor memory
	Cold Intolerance	**General**	
	Excessive thirst		Poor sleep/insomnia
	Excessive urination		Fatigue/low energy
	Hair loss		Fever or shaking chills
	Change in weight		Poor appetite
Muscles/joints/bones		**Women only**	
	Joint pain		Change in periods
	Muscle pain		Vaginal itching or discharge
	Joint redness		Breast lumps
	Joint swelling		Bleeding after menopause
		Men only	
			Testicular swelling
			Change in urinary stream