MOUNT CARMEL
Medical Group

Health History Questionnaire

Patient Name: _____ DOB: _____

Great healthcare is the result of great communication. At Mount Carmel Medical Group, we want to understand everything we can about your ideas on healthcare, your concerns, and your goals. Keeping you well means knowing you well. Thank you for beginning our conversation before your visit by completing this information.

Main reason for today's visit:

_____

Other concerns:

_____

_____

_____

ALLERGIES

Please list all allergies (medications, food, bee stings, etc.) and reactions to each.

ALLERGY	REACTION
1._____	_____
2._____	_____
3._____	_____
4._____	_____

MEDICATIONS

Please list all the medications you are currently taking. Include prescribed drugs and over-the-counter drugs, as well as vitamins and supplements.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____
7._____	_____	_____
8._____	_____	_____
9._____	_____	_____
10._____	_____	_____

IMMUNIZATION HISTORY

Immunizations and most recent date of administration:

Chickenpox	Date:_____	Meningococcus	Date:_____
Flu Shot	Date:_____	MMR *(Measles, Mumps, Rubella)*	Date:_____
Gardasil/HPV	Date:_____	Pneumonia	Date:_____
Hepatitis A	Date:_____	Tdap *(Tetanus and pertussis)*	Date:_____
Hepatitis B	Date:_____	Tetanus	Date:_____
		Zostavax *(Shingles)*	Date:_____

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PAST MEDICAL HISTORY

Please check all that apply:

☐ Anxiety Disorder	☐ Diverticulitis	☐ Kidney Disease
☐ Arthritis	☐ Fibromyalgia	☐ Kidney Stones
☐ Asthma	☐ Gout	☐ Leg/Foot Ulcers
☐ Bleeding Disorder	☐ Pacemaker	☐ Liver Disease
☐ Blood Clots (or DVT)	☐ Heart Attack	☐ Osteoporosis
☐ Cancer	☐ Heart Murmur	☐ Polio
☐ Coronary Artery Disease	☐ Hiatal Hernia or Reflux Disease	☐ Pulmonary Embolism
☐ Claustrophobic	☐ HIV or AIDS	☐ Reflux or Ulcers
☐ Diabetes - Insulin	☐ High Cholesterol	☐ Stroke
☐ Diabetes - Non-Insulin	☐ High Blood Pressure	☐ Tuberculosis
☐ Dialysis	☐ Overactive Thyroid	☐ Other _____

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Date of last pap smear	_____	☐ Normal ☐ Abnormal
Date of last mammogram	_____	☐ Normal ☐ Abnormal
Age of first menstrual period	_____	
Date of last menstrual period	_____	
Age at menopause	_____	

Number of pregnancies: _____ Number of births: _____ Number of abortions: _____

Number of miscarriages: _____ Number of cesarean sections: _____

FAMILY HISTORY

Grandmother (maternal)	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension
Grandfather (maternal)	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension
Grandmother (paternal)	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension
Grandfather (paternal)	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension
Father	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension

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Health History Questionnaire

Mother	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension
Brother	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension
Sister	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension
Other	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension

SOCIAL HISTORY

Education	☐ Less than 8th grade ☐ High school graduate ☐ 2 year college ☐ 4 year college ☐ Post graduate	**Marital Status**	☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner
Exercise Level	☐ None ☐ Occasional ☐ Moderate ☐ Heavy	**Caffeine**	☐ None ☐ Occasional ☐ Moderate ☐ Heavy Cups/cans daily? _____
Drugs	Do you use illicit drugs?		If yes please list: ☐ Yes ☐ No
Alcohol	Do you drink alcohol?	☐ Yes ☐ No	If so how often? ☐ Occasionally ☐ Less than 3 times a week ☐ More than 3 times a week
Tobacco	Do you use tobacco?	☐ Yes ☐ No	If not currently, did you ever use? ☐ Cigarettes- _____ pks per day ☐ Chew- _____ pks per day ☐ Cigars-_____ each per day Number of years used: _____ Year quit: _____

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL

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REVIEW OF SYSTEMS

Constitutional:	Eyes:	Ears and Nose:	Mouth and Throat:
☐ Fever ☐ Night sweats ☐ Weight gain ☐ Weight loss ☐ Exercise intolerance	☐ Dry eyes ☐ Vision change ☐ Irritation	☐ Difficulty hearing ☐ Ear pain ☐ Frequent nosebleeds ☐ Nose problems ☐ Sinus problems	☐ Sore throat ☐ Bleeding gums ☐ Snoring ☐ Dry mouth ☐ Mouth ulcer ☐ Oral abnormalities ☐ Teeth problems
Cardiovascular:	**Respiratory:**	**Gastrointestinal:**	**Genitourinary:**
☐ Chest pain ☐ Arm pain on exertion ☐ Shortness of breath when walking ☐ Shortness of breath when lying down ☐ Palpitations ☐ Known heart murmur	☐ Cough ☐ Wheezing ☐ Shortness of breath ☐ Coughing up blood ☐ Sleep apnea	☐ Abdominal pain ☐ Vomiting ☐ Change in appetite ☐ Diarrhea ☐ Vomiting blood ☐ Indigestion ☐ GERD	☐ Incontinence ☐ Difficulty urinating ☐ Blood in urine ☐ Increased frequency
Musculoskeletal:	**Integumentary:**	**Neurologic:**	**Psychiatric:**
☐ Muscle aches ☐ Muscle weakness ☐ Joint pain ☐ Back pain ☐ Swelling in extremities	☐ Abnormal mole ☐ Jaundice ☐ Rash ☐ Laceration	☐ Loss of consciousness ☐ Weakness ☐ Numbness ☐ Seizures ☐ Dizziness ☐ Migraines ☐ Headaches ☐ Tremors	☐ Depression ☐ Sleep disturbances ☐ Unsafe relationship ☐ Alcohol abuse ☐ Anxiety ☐ Hallucinations ☐ Suicidal thoughts
Endocrine:	**Hematologic/Lymphatic:**	**Allergic/Immunologic:**	**Other/not listed:**
☐ Fatigue	☐ Swollen glands ☐ Bruising ☐ Excessive bleeding	☐ Runny nose ☐ Sinus pressure ☐ Itching ☐ Hives ☐ Frequent Sneezing	

Please add any additional health information here:

_____

_____

_____

_____

_____ _____

Patient, Parent, Guardian, or Caregiver Signature **Date**

_____ _____

Provider Signature **Date**