



<h2 style="margin: 0;">Health History Questionnaire</h2>
--

BASIC INFORMATION

Legal Last Name	Legal First Name	M.I.
Preferred Name		
Legal Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth
Home Address	City	State Zip Code
Contact Method <input type="checkbox"/> Home Phone () - () - ()	<input type="checkbox"/> Cell Phone () - ()	<input type="checkbox"/> Day Phone () - ()
Preferred Language to Speak, Read & Write		Do you need a Translator : <input type="checkbox"/> Yes <input type="checkbox"/> No

HISTORY OF HEALTH CARE SERVICES
--

Did you previously have a Primary Care Provider (PCP)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name(s) of PCP
Have you ever seen a Specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name(s) of Specialist
Where have you previously received healthcare? <input type="checkbox"/> Hawaii Pacific Health <input type="checkbox"/> Queen's Medical Center <input type="checkbox"/> Kaiser <input type="checkbox"/> VA/ Tripler <input type="checkbox"/> Urgent Care <input type="checkbox"/> Private Practice Office (please list): <input type="checkbox"/> Other (please list):	

MEDICATION & ALLERIGIES

Do you have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If YES, please provide more information below.	
Name	Reaction
Name	Reaction
Name	Reaction
What Pharmacy do you prefer?	



Do you take medications on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you take any supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	--

Please list the names of your medications and/or supplements below. If you have trouble remembering, please look at your medication or supplement bottle.

HABITS

Do you use Tobacco (Chew/ Smoke/ E-cigs) ? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Chew <input type="checkbox"/> Smoke <input type="checkbox"/> E-cigs # per day:
Do you drink Alcohol (Beer/Wine/Hard/ Liquor) ? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Hard <input type="checkbox"/> Liquor # per day :
Do you use Street Drug (Marijuana/ Ice/ Cocaine) ? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Marijuana <input type="checkbox"/> Ice <input type="checkbox"/> Cocaine # per day :

MEDICAL HISTORY

Have you ever been hospitalized overnight ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please list reason for hospitalization and the date when you were hospitalized.	
Reason:	Date: (MM/YY):
Reason:	Date: (MM/YY):
Reason:	Date: (MM/YY):
Reason:	Date: (MM/YY):



GENERAL MEDICAL HISTORY: Please check conditions you have NOW or HAVE HAD in the past

Alcohol Abuse	Drug Abuse	Mental Illness
Anemia	Growth/Development Disorders	Migraines
Anesthetic Complication	Hearing Impairment	Osteoporosis
Anxiety Disorder	Heart Attack	Prostate Cancer
Arthritis	Heart Disease	Rectal Cancer
Asthma	Heart Pain / Angina	Reflux / GERD
Autoimmune Problems	Heart Problem	Seizures / Convulsions
Birth Defects	Hepatitis A	Severe Allergy
Bladder Problems	Hepatitis B	Sexually Transmitted Disease
Bleeding Disorder	Hepatitis C	Skin Cancer
Blood Clots	High Blood Pressure	Stoke / CVA of the Brain
Blood Transfusion(s)	High Cholesterol	Suicide Attempts
Bowel Disease	HIV / AIDS	Thyroid Problems
Breast Cancer	Hives	Ulcer
Cervical Cancer	Kidney Disease	Visual Impairment
Colon Cancer	Liver Cancer	Weight Problems
Depression	Lung Cancer	Other Significant Medical Problems: List Below
Diabetes	Lung/Respiratory Disease	

PRIMARY HEALTH CONCERNS

What is your biggest health concern that you would like us to address at your first visit?

Date Inputted: _____ Staff Initial: _____