

**University of North Dakota
Center for Family Medicine-Bismarck Patient Health History Questionnaire**

This information will become a part of your medical record and will be considered confidential.
This health history will be updated with each visit, as appropriate.

Do you have an Advance Directive, Living Will and/or Power of Attorney? YES NO

If YES, do we have a copy in our medical records? YES NO/At your hospital? YES NO

HEALTH HISTORY: Please place a (✓) check mark in the appropriate box if you have any of the following health problems or habits

Allergies

- Pollen, dust, molds, etc.
- Insect(s)
- Animal(s)
- Food(s) _____

Vision / Hearing / Pain

- Hearing deficit or hearing aids
- Glaucoma
- Chronic pain
- Cataracts

Lung

- Asthma
- Emphysema
- Tuberculosis
- Smoking

Heart

- Congestive Heart Failure
- Heart Disease
- High Blood Pressure
- Pacemaker
- Heart Murmur
- Irregular Heart Beat
- Rheumatic Fever
- Mitral Valve Disease
- Phen-Phen (past use)

Stomach / Urinary Tract

- High Blood Sugar
- High Cholesterol
- Overweight
- Ulcer/Heartburn
- Kidney Disease
- Hiatal hernia

Bone /Joint / Nervous System

- Lower Back Pain
- Osteoporosis
- Seizures
- Stroke
- Arthritis

Immune / Glands

- Hepatitis
- Thyroid Problems
- Diabetes _____

Other

- Cancer
(please identify type) _____
- Recreational drug use or history of abuse or rehab

SURGICAL HISTORY: Please list what kind of surgery and approximate year?

Surgery:	Approximate Year:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HEALTH HISTORY: Please place a (✓) check mark in the appropriate box if you have a family history of any of the following health problems and with the letter codes, indicate which family member it relates to:

F = Father M = Mother B=Brother S=Sister C=Child GP=Grand Parent

- | | | |
|--|--|---|
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> TB _____ | <input type="checkbox"/> Colon or Breast CA _____ |
| <input type="checkbox"/> Kidney problems _____ | <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Emphysema _____ | <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Other forms of Cancer _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Ulcer _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Problems with anesthesia _____ |
| | <input type="checkbox"/> High Cholesterol _____ | |

SOCIAL HISTORY:

Married Widowed Single Divorced Children (list number) _____

Occupation(s): _____ Recreation: _____

Have you used the following substances? School: _____

Currently Use	Previously Used	Type/Amount/Frequency	How Long?	If stopped, when?
Tobacco <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO			
Alcohol <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO			

Reviewed & Updated by:

Initials

Date

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Label

Patient Name: _____

Patient Address: _____

Patient DOB: _____

Date: _____