HEALING IN HIS WINGS, INC.
Health History Questionnaire

Date: _____/_____/_____

Chart#: _____

Name: _____ Date of Birth: _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____ SS#: _____ - _____ - _____

Telephone: _____ (Home) _____ (Cell)

Emergency Contact _____ Relationship: _____

Address: _____ Telephone: _____

How did you hear about the Safety Net Clinic? _____

Why are you visiting here today? _____

PERSONAL MEDICAL HISTORY

Check ☒ symptoms/conditions you currently have or have ever had in the past

- ☐ AIDS
- ☐ Alcoholism
- ☐ Allergies/Hay Fever
- ☐ Anemia (low blood)
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Benign Prostatic Hypertrophy
- ☐ Bipolar Disorder
- ☐ Bleeding Disorders/Bruising
- ☐ Bladder Infections
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer *Type* _____
- ☐ Cataracts
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy (fits, seizures)
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease/Infections
- ☐ Lactose Intolerance
- ☐ Leg Pain
- ☐ Liver Disease
- ☐ Lupus
- ☐ Menopause
- ☐ Migraine Headaches
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Pelvic Inflammatory Disease
- ☐ Pneumonia
- ☐ Prostatitis
- ☐ Sarcoidosis
- ☐ Schizophrenia
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Stomach Problems/ Ulcers
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Urethritis
- ☐ Uterine Fibroids
- ☐ Varicose Veins

- ☐ Other _____

SYMPTOMS/CONDITIONS

Check ☒ symptoms you currently have or have had in the past month.

General

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Frequent Headaches
- ☐ Frequent Tiredness
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Loud snoring
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Thirst

Gynecological (Women Only)

- ☐ Breast lump
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Pain during sex
- ☐ Unpleasant vaginal odor
- ☐ Vaginal discharge
- ☐ Vaginal infections
- ☐ Vaginal itching or burning

Muscle/Joint/Bone

Pain, weakness, numbness or tingling in:

- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

Eye, Ear, Nose, Throat, Lungs

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nasal congestion
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos
- ☐ Wheezing

Urinary

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Penile discharge
- ☐ Strong urge to urinate
- ☐ Urinating more than 3 times a night

Cardiovascular

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

Gastrointestinal

- ☐ Appetite poor
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Skin

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

List the medications that you are currently taking.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any foods or medicines? ☐ Yes ☐ No

If yes, what items? What happens to you when exposed to these items? _____

_____

Have you ever been hospitalized? ☐ Yes ☐ No If yes:

Year _____ Reason _____

Year _____ Reason _____

Year _____ Reason _____

Have you ever had surgery? ☐ Yes ☐ No If yes:

Year _____ Procedure _____

Year _____ Procedure _____

Year _____ Procedure _____

How many times a week do you exercise? _____ What types of exercise(s) do you do? _____

How would you describe your health on a scale of 1 to 10 (1 being poor and 10 being excellent)?

1 2 3 4 5 6 7 8 9 10

poor **excellent**

FAMILY HISTORY

Does anyone in your family have the following conditions? Relationship (mother, father, brother, sister, child)?

Allergies ( ) _____

Asthma ( ) _____

Dementia ( ) _____

Diabetes ( ) _____

Heart Disease ( ) _____

High Blood Pressure ( ) _____

Kidney Disease ( ) _____

Tuberculosis ( ) _____

Cancer – What type? ( ) _____

SEXUAL HISTORY

Have you ever had any of the following?

- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Trichomonas
- ☐ Herpes
- ☐ Syphilis
- ☐ Yeast
- ☐ Bacterial Vaginosis
- ☐ Human Papiloma Virus (HPV)

Have you ever had sex with?

- ☐ Men
- ☐ Women
- ☐ Both

Have you ever had sex with someone who is an IV drug user, or who is bisexual or gay? ☐ Yes ☐ No

Are you experiencing any problems with sexual intercourse? ☐ Yes ☐ No

If yes, what and how often? _____

_____

Do you use condoms to protect yourself from STDs (Sexually Transmitted Diseases)? ☐ Yes ☐ No

If not, why not? _____

_____

OB/GYN HISTORY (Women Only)

General

Have you ever had a pap smear? ☐ Yes ☐ No

Date of last pap smear _____/_____/_____

Have you ever had an abnormal pap smear?
☐ Yes ☐ No
If yes, when and where were you treated?
_____/_____/_____ _____

Do you do breast self-exams every month?
☐ Yes ☐ No
If no, how often? _____

Do you have any discharge from your breasts?
☐ Yes ☐ No

Do you have any breast masses or lumps?
☐ Yes ☐ No

Date of last mammogram? _____/_____/_____
☐ Normal Results
☐ Abnormal Results

Are you sexually active? ☐ Yes ☐ No

Menstrual History

Age you were when periods started _____

Have you gone through menopause?
☐ Yes ☐ No

Are your periods regular?
☐ Yes ☐ No ☐ Varies

Date of last period _____/_____/_____

How many days are your there from the start of one period to the beginning of the next? _____

How many days do your periods last? _____
Flow: ☐ Light ☐ Medium ☐ Heavy

Describe the intensity of pain you experience with your periods: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Crippling

Do you have bleeding or spotting between your periods?
☐ Yes ☐ No

Do you have bleeding or spotting after sex?
☐ Yes ☐ No

Birth Control

What method(s) for birth control do you currently use? _____

Have you ever taken birth control pills?
☐ Yes ☐ No

If yes, when and for how long? _____
_____

Other form(s) of birth control you have used:
_____
_____

Pregnancy History

Have you ever been pregnant? ☐ Yes ☐ No

If yes, how many times have you been pregnant? __

Have you ever had an abortion? ☐ Yes ☐ No
If yes, how many? _____
When? _____ _____ _____ _____ _____

How many children do you have? _____

Do you breastfeed? ☐ Yes ☐ No

Have any of your children died?
☐ Yes How many? _____ ☐ No

Were any of your children premature?
☐ Yes ☐ No

Have you ever had a miscarriage, stillborn child, or abortion? ☐ Yes ☐ No

How old were you when you had your first child?
_____

Do you have infertility problems? ☐ Yes ☐ No

If yes, please describe: _____
_____
_____

SOCIAL HISTORY

What is your current work status?
☐ Unemployed
☐ Part-Time job
☐ Full-Time job

What is the highest grade level you have completed?
☐ Elementary (grades 1 – 8)
☐ High School (grades 9 – 12)
☐ GED
☐ HS diploma
☐ Vocational training
☐ Some college
☐ Bachelor's degree
☐ Graduate degree

Do you smoke cigarettes or cigars? ☐ Yes ☐ No
If yes, how many per day? _____
If yes, for how many years? _____

Do you chew tobacco? ☐ Yes ☐ No
If yes, how often per day? _____

Do you drink beer, wine or liquor? ☐ Yes ☐ No
If yes, do you do so: ☐ Daily ☐ Weekly
☐ Monthly ☐ Every now and then
For how many years? _____

Do you use any of the following drugs?
To answer please use the codes below:
Past/Current (P/C)
Daily/Weekly/Monthly/Every Now & Then (D/W/M/E)
For how many years?

Crystal Meth: ☐ Yes ☐ No
If yes: _____ _____ _____
P/C D/W/M/E # of years

Marijuana/Blunts: ☐ Yes ☐ No
If yes: _____ _____ _____
P/C D/W/M/E # of years

Heroin: ☐ Yes ☐ No
If yes: _____ _____ _____
P/C D/W/M/E # of years

Crack: ☐ Yes ☐ No
If yes: _____ _____ _____
P/C D/W/M/E # of years

Cocaine: ☐ Yes ☐ No
If yes: _____ _____ _____
P/C D/W/M/E # of years

Have you ever been kicked, hit, or punched by your spouse/boyfriend/girlfriend/partner?
☐ Yes ☐ No
If yes, when _____/_____/_____
If yes, are you still dating or living with this person?

Have you ever been forced to have sex? ☐ Yes ☐ No
If yes, at what age? _____

NUTRITION HISTORY

How many fruits and vegetables do you usually eat each day?
0 – 2 _____ 3 – 5 _____ 6 or more _____

How many servings of caffeine (e.g. coffee, tea, Coke) do you have a day?
None _____ 1 – 3 _____ 4 – 6 _____ more than 6 _____

YOUR HEALTH INTERESTS

Are you interested in attending workshops, seminars, or classes on any of the following health topics? Check all that apply.

☐ Aerobics/Exercise
☐ Depression
☐ Diabetes
☐ Heart Disease/Hypertension
☐ Nutrition/Diet
☐ Smoking Cessation