TRIPLE O MEDICAL
SERVICES PA.

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Health History Questionnaire

All questions contained within this questionnaire are
strictly confidential and will become a part of your medical record.

List any diagnosed medical problems

Surgeries		
Year	Reason	Hospital

Other Hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ NO ☐ YES

List your prescribed drugs and over-the-counter medications, including vitamins and inhalers		
Name of Drug	Strength	Frequency Taken

Allergies to Medications	
Name of Drug	Reaction

WOMEN ONLY	
Age of onset of menstruation:	
Date of last menstruation:	
Period every _____ days	
Heavy periods, irregularity, spotting, pain or discharge?	☐ Yes ☐ No
Number of pregnancies:_____ Number of live births _____	
Are you pregnant or breastfeeding?	☐ Yes ☐ No
Have you had a D&C, hysterectomy or Cesarean?	☐ Yes ☐ No
Any urinary tract, bladder or kidney infection within the past year?	☐ Yes ☐ No
Any blood in your urine?	☐ Yes ☐ No
Any problems with control of urination?	☐ Yes ☐ No
Any hot flashes or night sweats?	☐ Yes ☐ No
Do you have menstrual tension, pain, bloating, irritability or other symptoms around your period?	☐ Yes ☐ No
Experienced any breast tenderness, lumps or nipple discharge?	☐ Yes ☐ No
Date of last pap and rectal exam?	

MEN ONLY	
Do you usually get up to urinate during the night?	☐ Yes ☐ No
If yes, how many times: _____	
Do you feel pain or burning with urination?	☐ Yes ☐ No
Any blood in your urine?	☐ Yes ☐ No
Do you feel burning discharge from the penis?	☐ Yes ☐ No
Has the force of your urination decreased?	☐ Yes ☐ No
Have you had any kidney, bladder or prostate infection in the past year?	☐ Yes ☐ No
Do you have any problems emptying your bladder completely?	☐ Yes ☐ No
Any difficulty with ejaculation or erection?	☐ Yes ☐ No
Any testicle pain or swelling?	☐ Yes ☐ No
Date of last prostate and rectal exam?	

Other Problems		
Check if you have, or have had any symptoms in the following areas to a significant degree. Please explain		
☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy Level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort
☐ Lungs	☐ Circulation	

Family History		
Check if anyone in your family has any of the following conditions. Please explain		
☐ Hypertension	☐ Diabetes Mellitus	☐
☐ Cancer	☐ Thyroid Problems	☐
☐ High Cholesterol	☐ Genetic Disorder	☐
☐ Kidney Disease	☐	☐
☐ Asthma	☐	☐

HEALTH HABITS AND SOCIAL HISTORY		
ALL QUESTIONS CONTAINED HERE ARE OPTIONAL AND ARE STRICTLY CONFIDENTIAL		
Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Cola	
	# of cups/cans per day?	
Alcohol	Do you drink alcohol?	☐ Yes ☐ No
	If yes, what kind?	
	How many drinks per week?	☐ Yes ☐ No
	Are you concerned about the amount you drink?	☐ Yes ☐ No
	Have you considered stopping?	☐ Yes ☐ No
	Have you ever experienced blackouts?	☐ Yes ☐ No
	Are you prone to "binge" drinking?	☐ Yes ☐ No
	Do you drive after drinking?	☐ Yes ☐ No
Tobacco	Do you use tobacco?	☐ Yes ☐ No
	☐ Cigarettes – packs per day ☐ Chew - #/ day ☐ Pipe - #/day ☐ Cigars - #/day	
	☐ # of years ☐ or year quit	
Drugs	Do you currently use recreational or street drugs?	☐ Yes ☐ No
	Have you ever given yourself drugs with a needle?	☐ Yes ☐ No
Travel	Have you ever traveled outside of the United States?	☐ Yes ☐ No
	Have you traveled within the past 5 years outside of the United States?	☐ Yes ☐ No
	If yes to above, where?	
Home	Do you have pets at home?	☐ Yes ☐ No
Sex	Are you sexually active?	☐ Yes ☐ No
	If yes, are you trying for pregnancy?	☐ Yes ☐ No
	If not trying for pregnancy, list contraceptive or barrier method:	
	Any discomfort with intercourse?	☐ Yes ☐ No
	Illness related to HIV, such as AIDS, has become a major public health problem. Risk factors for this include intravenous drug use and unprotected sexual intercourse. Would you like to speak to your provider about your risk for this illness?	☐ Yes ☐ No

MENTAL HEALTH	
Is stress a major problem for you?	☐ Yes ☐ No
Do you feel depressed?	☐ Yes ☐ No
Do you panic when stressed?	☐ Yes ☐ No
Do you have problems with eating or your appetite?	☐ Yes ☐ No
Do you cry frequently?	☐ Yes ☐ No
Have you ever attempted suicide?	☐ Yes ☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes ☐ No
Do you have trouble sleeping?	☐ Yes ☐ No
Have you ever been to a counselor?	☐ Yes ☐ No