BE WELL PRIMARY CARE
19600 E. Parker Square Dr. Ste 120
Parker, CO 80134
720-770-0966

INTERNAL MEDICINE HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

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

FAVORITE PHARMACY: _____

MEDICATIONS:

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

	DRUG NAME	**STRENGTH**	**FREQUENCY TAKEN**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

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6._____ _____ _____

7._____ _____ _____

8._____ _____ _____

9._____ _____ _____

10._____ _____ _____ _____

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ Abnormal _____
Last Mammogram Date _____ Abnormal _____
Age of first menstrual period: _____
Date of last menstrual period or age of menopause: _____
Number of pregnancies: _____ births: _____ miscarriages: _____ abortions: _____
Cesarean sections If yes, then number: _____
Additional GYN:

Bleeding between periods	Hot flashes	Vaginal itching, burning, or discharge
Heavy periods	Painful intercourse	
Extreme menstrual pain	Breast lump or nipple discharge	Wake in the night to go to the bathroom

Sexually active: _____
Current sexual partner is: Female Male
Do you use condoms: Yes No
Other Birth control method used: _____
Interested in being screened for STD's _____

PAST MEDICAL HISTORY

Please check all that apply:

Anxiety Disorder	Cancer	Diabetes - Non-Insulin
Arthritis	Coronary Artery Disease	Dialysis
Asthma	Claustrophobic	Diverticulitis
Bleeding Disorder	Diabetes - Insulin	Fibromyalgia
Blood Clots (or DVT)		Gout

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Has Pacemaker
Heart Attack
Heart Murmur
Hiatal Hernia or Reflux Disease
HIV or AIDS
High Cholesterol
High Blood Pressure
Overactive Thyroid
Kidney Disease
Kidney Stones
Leg/Foot Ulcers
Liver Disease
Osteoporosis
Polio
Pulmonary Embolism
Reflux or Ulcers
Stroke
Tuberculosis
Other

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N		Alcoholism Arthritis Depression Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke Cancer: _____
Grandfather (maternal)	Y/N		Alcoholism Arthritis Depression Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke Cancer: _____
Grandmother (paternal)	Y/N		Alcoholism Arthritis Depression Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke Cancer: _____
Grandfather (paternal)	Y/N		Alcoholism Arthritis Depression Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke Cancer: _____
Father	Y/N		Alcoholism Arthritis Depression Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke Cancer: _____

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Mother	Y/N		Alcoholism Arthritis Depression Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke Cancer: ____________________
Sibling: Brother/Sister	Y/N		Alcoholism Arthritis Depression Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke Cancer: ____________________
Sibling: Brother/Sister	Y/N		Alcoholism Arthritis Depression Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke Cancer: ____________________
Sibling: Brother/Sister	Y/N		Alcoholism Arthritis Depression Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke Cancer: ____________________
Sibling: Brother/Sister	Y/N		Alcoholism Arthritis Depression Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke Cancer: ____________________

SOCIAL HISTORY

Education: Less than 8th grade High school 2 year college 4 year college Post graduate

Marital Status: Married Single Divorced Separated Widowed Domestic partner

Exercise Level: None (No exercise) Occasional exercise Moderate exercise High level exercise

Caffeine: None Occasional Moderate Heavy # of cups/cans per day? ____

Alcohol: Do you drink alcohol? Yes No

If so, how often? Occasionally < 3 times a week > 3 times a week How many drinks per week? _____

Tobacco: Do you use tobacco? Yes No If not currently, did you ever use tobacco? Yes No

Cigarettes -____pks./day Chew - ____/day Cigars - _____/day # of years____ Or year quit __________

Drugs: Do you currently use recreational or street drugs? Yes No

If yes, list: ____

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REVIEW OF SYSTEMS

Please check all that apply- that you are currently experiencing:

Allergic/Immunologic
Frequent Sneezing
Hives
Itching
Runny Nose
Sinus Pressure

Cardiovascular
Arm Pain on Exertion
Chest Pain on Exertion
Chest Heaviness/Pressure on Exertion
Irregular Heart Beats (Palpitations)
Known Heart Murmur
Light-headed on Standing
Shortness of Breath When Lying Down
Shortness of Breath When Walking
Swelling (edema)

Constitutional
Exercise Intolerance
Fatigue
Fever
Weight Gain (____lbs)
Weight Loss (____lbs)

Eyes
Dry Eyes
Irritation
Vision Change
Date of Last Exam:_____

Ears/Nose/Mouth/Throat
Bleeding Gums
Difficulty Hearing
Dizziness
Dry Mouth
Ear Pain
Frequent Infections
Frequent Nosebleeds
Hoarseness
Mouth Breathing
Mouth Ulcers
Nose/Sinus Problems
Ringing in Ears

Endocrine
Fatigue
Increased- Thirst/Hunger/Urination

Gastrointestinal
Abdominal Pain
Black or Tarry Stool
Blood in Stool
Change in Appetite
Frequent Indigestion
Hemorrhoids
Trouble Swallowing
Vomiting
Vomiting Blood

Genitourinary
Blood in Urine
Difficulty Urinating
Incomplete Emptying
Increased Urinary Frequency
Urinary Loss of Control

Hematologic/Lymphatic
Easy Bruising/Bleeding
Swollen Glands

Integumentary (Skin)
Changes in Moles
Dry Skin
Eczema
Growth/Lesions
Itching
Jaundice (Yellow Skin/Eyes)
Rash

Musculoskeletal
Back Pain
Joint Pain
Muscle Aches
Muscle Weakness

Neurological
Dizziness
Fainting
Headaches
Memory Loss
Migraines
Numbness
Restless Legs
Seizures
Weakness

Psychiatric
Alcohol Overuse
Anxiety/Stress
Depression
Do Not Feel Safe in Relationship
Mania
Sleep Problems

Respiratory
Cough
Coughing Up Blood
Shortness of Breath
Sleep Apnea
Snoring
Wheezing

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Please add any other information about your health that you would like your provider to know here:

_____

_____

_____

_____

Patient or Parent, Guardian, or Caregiver Signature: _____

Date: _____