Two Rivers Family Practice
1231 South Patrick Drive,
Satellite Beach, FL 32937

Medical Health History Questionnaire

Information provided on this form will assist your health care provider to better understand your medical conditions and concerns. All questions are optional and will be kept confidential.

Patient Name:_____ DOB:_____ Today's Date:_____

ALLERGIES **NO KNOWN ALLERGIES** ☐

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

ALLERGY	REACTION
1	
2	
3	

MEDICATIONS

PLEASE LIST ALL PRESCRIBED DRUGS AND OVER THE COUNTER DRUGS SUCH AS VITAMINS AND INHALERS

DRUG NAME	STRENTH	FREQUENCY TAKEN	REFILLS NEEDED
1			☐YES ☐No
2			☐YES ☐No
3			☐YES ☐No
4			☐YES ☐No
5			☐YES ☐No
6			☐YES ☐No
7			☐YES ☐No
8			☐YES ☐No
9			☐YES ☐No
10			☐YES ☐No
11			☐YES ☐No
12			☐YES ☐No
13			☐YES ☐No
14			☐YES ☐No
15			☐YES ☐No

Immunization History

Flu Shot	Date:_____	Measles/Mumps/Rubella(MMR)	Date:_____
Tetanus/Diphtheria/Pertussis (DPT)	Date:_____	Pneumonia Vaccine	Date:_____
Chickenpox	Date:_____	Human Papillimavirus (HPV)	Date:_____
Meningitis Vaccine	Date:_____	Td or Tdap	Date:_____
Hepatitis A (2 shot series)	Date(s):_____	COVID Vaccine	Date(s):_____
Hepatitis B (3 shot series)	Date(s):_____	Shingles	Date: _____

Past Medical History (please check all that apply)

- ☐ GERD/Heartburn
- ☐ Ulcers
- ☐ Colon Polyps
- ☐ Irritable Bowel Syndrome
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Diverticulosis
- ☐ Pancreatitis
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ High Blood Pressure (HTN)
- ☐ Coronary Artery Disease (CAD)
- ☐ Cardiac Stent
- ☐ Bladder or Kidney Issues
- ☐ Sleep Apnea
- ☐ Cataracts
- ☐ Measles/Mumps/Chickenpox/Polio
- ☐ Rubella
- ☐ Rheumatic Fever
- ☐ Abnormal Vaginal Bleeding
- ☐ Congestive Heart Failure (CHF)
- ☐ Atrial Fibrillation
- ☐ Pacemaker
- ☐ AICD(Defibrillator)
- ☐ COPD
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Elevated Cholesterol
- ☐ TIA/Stroke
- ☐ Fibromyalgia
- ☐ Arthritis
- ☐ DVT/Blood Clot
- ☐ Cancer (Type:_____)
- ☐ Dialysis
- ☐ Heart Attack
- ☐ Glaucoma
- ☐ Back pain
- ☐ Headaches/Migraines
- ☐ Parkinson's Disease
- ☐ Recurrent Urinary Tract Infections (UTI)
- ☐ Epilepsy/Seizures
- ☐ Dementia/Alzheimer's
- ☐ Asthma
- ☐ Difficulty Sleeping
- ☐ Dizziness
- ☐ Kidney Stones
- ☐ Anxiety
- ☐ Depression
- ☐ Anemia
- ☐ Other: _____
- ☐ Other: _____

Men Only: *(if applicable)*

Date of last PSA (lab test) _____ Last Prostate Exam: _____

Pain or lump in testicles ☐YES ☐No Prostate problems ☐YES ☐No

Straining with urination ☐YES ☐No Sexual Difficulties ☐YES ☐No

Women Only: Obstetric and Gynecological History *(if applicable)*

Age at first Menstrual Cycle _____ Date of last menstrual cycle: _____

Date of last Pap Smear _____ Normal ☐ Abnormal ☐ Date of last DEXA Scan: _____

Date of last mammogram: _____ Normal ☐ Abnormal ☐ Abnormal vaginal bleeding ☐YES ☐No

Pelvic Pain ☐YES ☐No Sexual difficulties ☐YES ☐No

# of pregnancies__ live births___ miscarriages___ Age at First Child Birth _____

If Post-Menopausal, Age at Menopause _____ Post-Menopausal Bleeding ☐YES ☐No

Breast Augmentation ☐YES ☐No Breast Reduction ☐YES ☐No

Mastectomy ☐YES ☐No Hysterectomy ☐YES ☐No

Tubal Ligation ☐YES ☐No Cesarean Section ☐YES ☐No

Men and Women: *(if applicable)*

Date of Last Colonoscopy Date:_____ Location:_____ GI Doctor: _____ ☐Normal ☐Abnormal

Please list all Specialists who are involved with your care: (*If none skip to next*)

_____

_____

_____

_____

Surgical History		**Date/Year**			**Date/Year**
EGD (Upper Endoscopy)	☐	_____	Prostate Surgery	☐	_____
Ulcer Surgery	☐	_____	Back Surgery	☐	_____
Colon Surgery	☐	_____	Hip Surgery (R)(L)	☐	_____
Gallbladder Surgery	☐	_____	Knee Surgery (R)(L)	☐	_____
Appendectomy	☐	_____	Weight Loss Surgery	☐	_____
Hemorrhoidectomy	☐	_____	Heart Bypass Surgery	☐	_____
Heart Valve Replacement	☐	_____	Hysterectomy	☐	_____
Ovaries Removed (R)(L)	☐	_____	(partial/complete)		

Other Surgeries: _____

Patient Health Questionnaire-2 (PHQ-2)

Little interest or pleasure in doing things? ☐ Not at all ☐Several Days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed, or hopeless? ☐ Not at all ☐Several Days ☐ More than half the days ☐ Nearly every day

Family History (Please CHECK ALL that apply for each family member)

Maternal Grandmother ☐Alive (Age:____) ☐Deceased (Age:_____) ☐Unknown

☐Heart Attack ☐Heart Disease ☐Peripheral Vascular Disease ☐ Alcohol Abuse ☐Depression

☐High Blood Pressure ☐High Cholesterol ☐Diabetes ☐Stroke ☐COPD ☐Autism

☐Alzheimer's Disease ☐ Asthma ☐Disorder of Thyroid Gland ☐Obesity ☐Osteoporosis

☐Cancer If yes, what type: _____(Colon, Breast, etc)

Maternal Grandfather ☐Alive (Age:____) ☐Deceased (Age:_____) ☐Unknown

☐Heart Attack ☐Heart Disease ☐Peripheral Vascular Disease ☐ Alcohol Abuse ☐Depression

☐High Blood Pressure ☐High Cholesterol ☐Diabetes ☐Stroke ☐COPD ☐Autism

☐Alzheimer's Disease ☐ Asthma ☐Disorder of Thyroid Gland ☐Obesity ☐Osteoporosis

☐Cancer If yes, what type: _____(Colon, Breast, etc)

Paternal Grandmother ☐Alive (Age:____) ☐Deceased (Age:_____) ☐Unknown

☐Heart Attack ☐Heart Disease ☐Peripheral Vascular Disease ☐ Alcohol Abuse ☐Depression

☐High Blood Pressure ☐High Cholesterol ☐Diabetes ☐Stroke ☐COPD ☐Autism

☐Alzheimer's Disease ☐ Asthma ☐Disorder of Thyroid Gland ☐Obesity ☐Osteoporosis

☐Cancer If yes, what type: _____(Colon, Breast, etc)

Paternal Grandfather ☐Alive (Age:____) ☐Deceased (Age:_____) ☐Unknown

☐Heart Attack ☐Heart Disease ☐Peripheral Vascular Disease ☐ Alcohol Abuse ☐Depression

☐High Blood Pressure ☐High Cholesterol ☐Diabetes ☐Stroke ☐COPD ☐Autism

☐Alzheimer's Disease ☐ Asthma ☐Disorder of Thyroid Gland ☐Obesity ☐Osteoporosis

☐Cancer If yes, what type: _____(Colon, Breast, etc)

Mother ☐Alive (Age:____) ☐Deceased (Age:_____) ☐Unknown

☐Heart Attack ☐Heart Disease ☐Peripheral Vascular Disease ☐ Alcohol Abuse ☐Depression

☐High Blood Pressure ☐High Cholesterol ☐Diabetes ☐Stroke ☐COPD ☐Autism

☐Alzheimer's Disease ☐ Asthma ☐Disorder of Thyroid Gland ☐Obesity ☐Osteoporosis

☐Cancer If yes, what type: _____(Colon, Breast, etc)

Father ☐Alive (Age:____) ☐Deceased (Age:_____) ☐Unknown

☐Heart Attack ☐Heart Disease ☐Peripheral Vascular Disease ☐ Alcohol Abuse ☐Depression

☐High Blood Pressure ☐High Cholesterol ☐Diabetes ☐Stroke ☐COPD ☐Autism

☐Alzheimer's Disease ☐ Asthma ☐Disorder of Thyroid Gland ☐Obesity ☐Osteoporosis

☐Cancer If yes, what type: _____(Colon, Breast, etc)

Brother/Sister ☐Alive (Age:____) ☐Deceased (Age:_____) ☐Unknown

☐Heart Attack ☐Heart Disease ☐Peripheral Vascular Disease ☐ Alcohol Abuse ☐Depression

☐High Blood Pressure ☐High Cholesterol ☐Diabetes ☐Stroke ☐COPD ☐Autism

☐Alzheimer's Disease ☐ Asthma ☐Disorder of Thyroid Gland ☐Obesity ☐Osteoporosis

☐Cancer If yes, what type: _____(Colon, Breast, etc)

Brother Sister ☐Alive (Age:____) ☐Deceased (Age:_____) ☐Unknown

☐Heart Attack ☐Heart Disease ☐Peripheral Vascular Disease ☐ Alcohol Abuse ☐Depression

☐High Blood Pressure ☐High Cholesterol ☐Diabetes ☐Stroke ☐COPD ☐Autism

☐Alzheimer's Disease ☐ Asthma ☐Disorder of Thyroid Gland ☐Obesity ☐Osteoporosis

☐Cancer If yes, what type: _____(Colon, Breast, etc)

Social History (Please CHECK All that Apply)

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Life Partner ☐Legally Separated

Occupation: ☐Full Time ☐Part Time ☐Retired ☐Homemaker ☐Student ☐Unemployed ☐Disabled

Who Lives With You: ☐Spouse ☐Children ☐Partner ☐Mother ☐Father ☐ No One ☐Roommate

Exercise: ☐Never ☐Daily ☐1-2 times per week ☐ 3-4 times per week

Diet: ☐Yes ☐No ☐Physician prescribed diet

Caffeine Use: ☐None ☐Daily ☐1-3 cups/drinks a day ☐ 4 + cups/drinks per day

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Tobacco Use:

☐ **Current tobacco user**

Form: ☐ Cigarettes ☐Cigars ☐ Smokeless Tobacco ☐Chew
Amount: ☐ ½ PPD ☐1 PPD ☐2 PPD ☐More than 2 PPD
Duration: ☐ 0-5 years ☐6-10 Years ☐10-20 years ☐20+ years

☐ **Previous tobacco user**

Form: ☐ Cigarettes ☐Cigars ☐ Smokeless Tobacco ☐Chew
Amount: ☐ ½ PPD ☐1 PPD ☐2 PPD ☐More than 2 PPD
Duration: ☐ 0-5 years ☐6-10 Years ☐10-20 years ☐20+ years

If you quit, what year did you quit?_____

☐ **Never a tobacco user**

Are you exposed to "second-hand" smoke? ☐YES ☐No

Alcohol Use: ☐Never ☐Daily ☐Social Drinker ☐Trying to Quit ☐ Previously ☐Less than 12 drinks a month ☐1-12 drinks a month ☐4-15 drinks a week ☐more than 2 drinks a day

Medical Marijuana Use: ☐YES ☐No Prescriber: _____

Recreational Drug Use: ☐Never ☐Daily ☐Trying to Quit ☐Previously

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Previous Primary Care Provider

Name of Provider: _____ Phone: _____

Address: _____ Fax: _____

_____

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