



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	STRENGTH	FREQUENCY TAKEN	REFILLS NEEDED
1			<input type="checkbox"/> YES <input type="checkbox"/> No
2			<input type="checkbox"/> YES <input type="checkbox"/> No
3			<input type="checkbox"/> YES <input type="checkbox"/> No
4			<input type="checkbox"/> YES <input type="checkbox"/> No
5			<input type="checkbox"/> YES <input type="checkbox"/> No
6			<input type="checkbox"/> YES <input type="checkbox"/> No
7			<input type="checkbox"/> YES <input type="checkbox"/> No
8			<input type="checkbox"/> YES <input type="checkbox"/> No
9			<input type="checkbox"/> YES <input type="checkbox"/> No
10			<input type="checkbox"/> YES <input type="checkbox"/> No
11			<input type="checkbox"/> YES <input type="checkbox"/> No
12			<input type="checkbox"/> YES <input type="checkbox"/> No
13			<input type="checkbox"/> YES <input type="checkbox"/> No
14			<input type="checkbox"/> YES <input type="checkbox"/> No
15			<input type="checkbox"/> YES <input type="checkbox"/> No

Immunization History

Flu Shot	Date: _____	Measles/Mumps/Rubella(MMR)	Date: _____
Tetanus/Diphtheria/Pertussis (DPT)	Date: _____	Pneumonia Vaccine	Date: _____
Chickenpox	Date: _____	Human Papillomavirus (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)

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

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)	<input type="checkbox"/>	_____	Prostate Surgery	<input type="checkbox"/>	_____
Ulcer Surgery	<input type="checkbox"/>	_____	Back Surgery	<input type="checkbox"/>	_____
Colon Surgery	<input type="checkbox"/>	_____	Hip Surgery (R)(L)	<input type="checkbox"/>	_____
Gallbladder Surgery	<input type="checkbox"/>	_____	Knee Surgery (R)(L)	<input type="checkbox"/>	_____
Appendectomy	<input type="checkbox"/>	_____	Weight Loss Surgery	<input type="checkbox"/>	_____
Hemorrhoidectomy	<input type="checkbox"/>	_____	Heart Bypass Surgery	<input type="checkbox"/>	_____
Heart Valve Replacement	<input type="checkbox"/>	_____	Hysterectomy	<input type="checkbox"/>	_____
Ovaries Removed (R)(L)	<input type="checkbox"/>	_____	(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	<input type="checkbox"/> Alive (Age:____)	<input type="checkbox"/> Deceased (Age:____)	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Depression
	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Diabetes <input type="checkbox"/> Stroke <input type="checkbox"/> COPD <input type="checkbox"/> Autism
	<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Disorder of Thyroid Gland <input type="checkbox"/> Obesity <input type="checkbox"/> Osteoporosis
	<input type="checkbox"/> Cancer	If yes, what type: _____(Colon, Breast, etc)	
Maternal Grandfather	<input type="checkbox"/> Alive (Age:____)	<input type="checkbox"/> Deceased (Age:____)	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Depression
	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Diabetes <input type="checkbox"/> Stroke <input type="checkbox"/> COPD <input type="checkbox"/> Autism
	<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Disorder of Thyroid Gland <input type="checkbox"/> Obesity <input type="checkbox"/> Osteoporosis
	<input type="checkbox"/> 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

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

Previous Primary Care Provider

Name of Provider: _____

Phone: _____

Address: _____

Fax: _____
