Date:
Peter Christensen Health Center 129 Old Abe Road Lac du Flambeau, WI 54538 PH: (715) 588-3371 FAX: (715) 588-2039
To better prepare for your first appointment with us, please complete the following Health History Questionnaire and bring it with you to your appointment or return it via mail if you would like us to obtain medical records prior to your visit.

MEDICAL HEALTH HISTORY QUESTIONNAIRE

All question contained in this questionnaire are strictly confidential and will become part of your medical record

Name:						**DOB:**	
Gender Identity:	☐ Male	☐ Female	☐ Transgender Male	☐ Transgender Female	☐ Gender Queer	☐ Other	☐ Declined
Sexual Orientation:	☐ Straight	☐ Gay	☐ Lesbian	☐ Bisexual	☐ Other	☐ Unknown	☐ Declined
Marital Status:	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed	
Previous or referring doctor:					**Date of last physical exam:**		

PERSONAL HEALTH HISTORY

Childhood Illness:	☐ Measles	☐ Mumps	☐ Rubella	☐ Chicken Pox	☐ Rheumatic Fever	☐ Polio
Immunizations and dates:						

List any medical problems that other doctors have diagnosed

Year	Diagnosis

Surgeries:

Year	Reason	Hospital

Other Hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Known Allergies (Medication and/or Environmental)	
Name of Allergy	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL					
Exercise (check one that applies)	Sedentary (No exercise)				☐
	Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				☐
	Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 minutes)				☐
	Regular vigorous exercise (i.e., work for recreation 4x/week for 30 minutes)				☐
Nutrition	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	Number of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	Number of cups/cans per day				

Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If yes, what kind?		
	How many drinks per week?		
	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 – pks./day ☐ Chew - cans/day ☐ Pipe - #/day ☐ Cigars - #/day		
	☐ Number of years ☐ Or year quit		
	Commercial tobacco use (i.e. e-cig, vape, juul, etc.)	☐ Yes	☐ No
	If yes, what kind?		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Sex	Are you sexually active	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illnesses like Human Immunodeficiency Virus (HIV), AIDS, and Hep C have become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Do you feel safe in your home?	☐ Yes	☐ No
	Would you like to discuss physical, mental, or financial abuse?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	Age	Significant Health Problems (i.e. Heart Disease, Diabetes, Cancer, etc.)		Age	Significant Health Problems (i.e. Heart Disease, Diabetes, Cancer, etc.)
Father			**Children**	☐M ☐F	
Mother				☐M ☐F	
Sibling	☐M ☐F			☐M ☐F	
	☐M ☐F			☐M ☐F	
	☐M ☐F		**Grandmother** *Maternal*		
	☐M ☐F		**Grandfather** *Maternal*		
	☐M ☐F		**Grandmother** *Paternal*		
	☐M ☐F		**Grandfather** *Paternal*		

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

WOMEN ONLY		
Age at onset 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 infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent 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, number of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ 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 and briefly 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	

Patient Signature: _____ Date: _____

PCHC Staff Signature: _____ Received Date: _____