J. T. Lee, M.D., P.A.
HEALTH HISTORY QUESTIONNAIRE

Your answers on this form help your healthcare 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 QUESTINONAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main Reason for today's visit: _____

ALLERGIES/ADVERSE REACTION

*include MEDICATIONS, FOOD, BEE STINGS, ect. and how each affects you along with the severity.

Allergy (hypersensitivity to a medication that causes LIFE- THREATENING response)

Allergy:	Reaction:	Severity (please circle one):
1._____	1._____	Mild Moderate Severe
2._____	2._____	Mild Moderate Severe
3._____	3._____	Mild Moderate Severe

Adverse Reaction (Causes an UNWANTED SYMPTOM that prevents you from taking it)

Medication:	Reaction:	Severity (please circle one):
1._____	1._____	Mild Moderate Severe
2._____	2._____	Mild Moderate Severe
3._____	3._____	Mild Moderate Severe

Pharmacy

What is your preferred LOCAL pharmacy? _____
What is your MAIL-ORDER pharmacy?_____

MEDICATIONS

Please list ALL medications you are taking (prescription, over-the-counter drugs, vitamins, herbals, inhalers)
Drug Name/ STRENGTH/ HOW OFTEN YOU TAKE IT (ex: 1x/each day, 2x/each day, 1x/ each week) or attach a list to the back of this packet

1._____ 2. _____
3._____ 4. _____
5._____ 6. _____
7._____ 8. _____

J. T. Lee, M.D., P.A.

SPECIALISTS

Please list the name of any of the following Providers/Specialists that you see currently or have seen in the past:

Previous Primary Care Provider (PCP)?
_____

Cardiologist (Heart Doctor)
_____

Pulmonologist (Lung Doctor)
_____

Gastroenterologist (Stomach/Intestinal Doctor)
_____

Pain Management _____

Ophthalmologist (Eye Doctor)
_____

Psychiatrist _____

OB/GYN (Female Doctor) _____

Other: _____

_____

IMMUNIZATIONS

Influenza (Flu shot)		Date: _____	Where _____
Pneumococcal:	Pneumovax 23	Date: _____	Where _____
	Prevnar 13	Date: _____	Where _____
Shingrix	Dose #1	Date: _____	Where _____
	Dose #2	Date: _____	Where _____
Tdap (tetanus and pertussis)		Date: _____	Where _____
Td Booster (just tetanus)		Date: _____	Where _____
HPV	Date: _____ Date: _____	Date: _____	Where _____

PAST SURGICAL HISTORY

ANY REACTION TO ANESTHESIA? YES NO

When was your last colonoscopy? Date: _____ Where _____

Surgery	Approximate Date	Where: (ex. Hospital, Surgeon's office)
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____

SEXUAL HISTORY

Are you sexually active? YES NO

Current sexual partner is: MALE FEMALE BOTH

Do you or your partner use contraception? (ex. condoms, birth control, IUD?) YES NO N/A

Are in interested in being screened for Sexually Transmitted Infections (STI?) YES NO

J. T. Lee, M.D., P.A.

WOMEN ONLY (OBSTETRIC AND GYNECOLOGICAL HISTORY)

Last PAP smear Date: _____ Where _____

Last Mammogram Date: _____ Where _____

Age of First Menstrual Period: _____

Date of last menstrual period or age of menopause: _____

Number of Pregnancies _____ Number of Births _____ Number of Miscarriages _____ Number of abortions _____

Have you ever had a Cesarean section? YES NO If Yes, how many? _____

Please CIRCLE below if you experience any of the following:

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

PAST MEDICAL PROBLEMS

Please CIRCLE all that apply

- Anxiety
- Anemia
- Arthritis
- Asthma/COPD
- Bleeding Disorder
- Blood clots (DVT or Pulmonary Embolism)
- Cancer (what kind? _____)
- Coronary Artery Disease
- Claustrophobic
- Diabetes- Insulin
- Diabetes- Non-insulin
- Depression
- Diverticulosis
- Fibromyalgia
- Gout
- Pacemaker
- Heart attack
- Heart Murmur
- Hiatal Hernia/ Acid Reflux
- HIV/ AIDS
- High Cholesterol
- High Blood Pressure
- Irritable Bowel Syndrome (IBS)
- Kidney Disease
- Kidney Stones
- Leg/Foot Ulcers
- Liver Disease
- Lyme Disease
- Migraines
- Osteopenia/ Osteoporosis
- Seasonal Allergies
- Seizures
- Sleep Apnea
- Stroke
- Thyroid Problem
- Urinary Tract Infection

J. T. Lee, M.D., P.A.

SOCIAL HISTORY

EDUCATION

- Less than 8th grade
- Some High School/ High School diploma
- 2-year college
- 4-year college
- Some college
- Post Graduate degree

ALCOHOL

Do you drink alcohol? YES or NO
If so, how often:

- Less than 3 times each week
- 3 times a week
- Daily

In one sitting where you drink alcohol, how many glasses/beers do you have?

- 0-1
- 1-2
- 3-4
- >4

SMOKING

Do you currently smoke? YES NO

If yes, please circle:

Cigarettes Cigars Pipe Vape/Electronic Chew

At what age did you start smoking _____

If you quit, at what age/what year did you quit?
_____

How much per day: (past/present) _____

In the last two weeks:
Have you felt little interest or pleasure in doing things?

Not at all Several Days More than half the days Nearly every day

Have you felt down, depressed or hopeless?

Not at all Several Days More than half the days Nearly Every day

Caffeine

- None
- 1-2 cups/day
- 3-4 cups/day
- > 4 cups/day

Drugs

Do you currently or have you ever used recreational or street drugs?

YES NO

If yes, please list: _____

Have you ever been treated for substance abuse?

YES NO

EXERCISE

How often do you exercise?

- Not at all
- 1-2x/week
- 3-4x/week
- >4x/week

How many minutes per session?

- 10-15 minutes
- 15-30 minutes
- 30-45 minutes
- >45 minutes

What types of exercise do you participate in?
CIRCLE ALL THAT APPLY

- Cardio (Running/Treadmill)
- Strength (weight lifting)
- Yoga/Pilates
- Cycling/Bike
- Stretching
- Swimming

J. T. Lee, M.D., P.A.

CURRENT SYMPTOMS/COMPLAINTS

Please CIRCLE all that apply to you:

Constitutional • Exercise Intolerance • Fever/ Chills • Weight Gain (____lbs) • Weight Loss (____lbs)	**Genitourinary** • Blood in Urine • Burning with Urination • Incomplete Emptying • Increased Frequency • Urinary Loss of Control (leaking)	**Psychiatric** • Anxiety/Stress • Depression • Feel unsafe in relationship • Sleep Difficulties
Cardiovascular • Chest Pain on Exertion • Shortness of Breath with Exertion • Chest Heaviness/Pressure • Irregular Heart Beat/Palpitations • Known Heart Murmur • Lightheadness/Dizziness • Swelling legs	**Gastrointestinal** • Abdominal Pain • Black or Dark Stool • Blood in Stool • Change in Appetite • Heartburn • Hemorrhoids • Difficulty Swallowing • Nausea • Vomiting	**Eyes** • Dry Eyes • Vision Changes **Ears** • Difficulty Hearing • Ringing of the Ears **Nose** • Nosebleeds **Mouth** • Hoarseness • Bleeding Gums • Dry Mouth • Mouth Ulcers • Tooth Pain
Allergic/Immunologic • Frequent Sneezing • Hives • Itching • Runny Nose • Sinus Pressure	**Musculoskeletal** • Back Pain • Joint Pain • Muscle Aches • Muscle Weakness • Difficulty with Walking • History of fall in the last year	**Endocrine** • Fatigue • Increased Hunger • Increased Thirst • Increased Urination • Dry Skin • Thinning Hair
Respiratory • Cough • Shortness of breath • Snoring • Wheezing	**Neurological** • Fainting • Headaches • Memory Loss • Restless Legs • Weakness • Numbness/Tingling in Extremities	**Skin** • Changes in Moles • Eczema • Rash

Please list any additional information about your health that you would like your provider to aware of:

_____
_____
_____
_____
_____
_____
_____

J. T. Lee, M.D., P.A.

FAMILY HEALTH HISTORY

Please mark an X in the box if this condition was present for your family member

Relation	Alive ? Y/N	Age	Alcoholism	Arthritis	Depression/ Anxiety	Cancer (What type?)	Diabetes	Genetic Disease	Heart Disease	Heart Attack	High Blood Pressure	High Cholesterol	Osteoporosis	Stroke
Grandmother (Maternal)														
Grandfather (Maternal)														
Grandmother (Paternal)														
Grandfather (Paternal)														
Father														
Mother														
Brother/Sister														
Brother/Sister														
Child														
Child														
Other: _____														