COLORADO INTERNAL MEDICINE

A Concierge Medical Practice

HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help us 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.

Name: ____
Address: ____ Phone: _____________
City: _________________ State: _______ Zip: ______ SSN: ________________
Gender: ☐ Male ☐ Female ☐ Transgender ☐ Non-binary ☐ Prefer Not to Answer
Date of Birth: ____ /____ /____ (Month / Day / Year)
Guardian (if Applicable): ____
Emergency Contact Name: ______________________ Relationship:_______________
Emergency Contact Home Phone: _____________ Cell: _____________

Primary Insurance Information

Insurance Provider: ___________________________ Phone: _________________
Policy #: _____________________ Group #: ___________________
Subscriber Name: ____________________ Subscriber Date of Birth: ____ /____ /____ (Month / Day / Year)
Subscriber Relationship to Patient: ________________________________

Secondary Insurance Information

Insurance Provider: ___________________________ Phone: _________________
Policy #: _____________________ Group #: ___________________
Subscriber Name: ____________________ Subscriber Date of Birth: ____ /____ /____ (Month / Day / Year)
Subscriber Relationship to Patient: ________________________________

ALLERGIES

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

ALLERGY	REACTION
________________________________	________________________________

ALLERGY	REACTION

MEDICATIONS

Please list all the medications you are taking. Include prescribed medications, vitamins, supplements, and over-the-counter medications.

DRUG NAME, DOSE, & FREQUENCY TAKEN	REASON FOR TAKING	PRESCRIBED BY

PREFERRED PHARMACY

Please list all preferred local retail, compounding, or mail order pharmacies. Include their address and phone number.

1. ____________________
2. ____________________
3. ____________________

PAST MEDICAL HISTORY

Please mark all conditions that you have or have had.

- ☐ Anemia
- ☐ Anxiety
- ☐ Artery / Vein Problems
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Biliary Tract Disease
- ☐ Diverticulitis
- ☐ Eczema
- ☐ Endometriosis
- ☐ Enlarged Prostate
- ☐ Esophagitis
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Gallbladder Problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV / AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Immunosuppressant Condition
- ☐ Infertility
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Parkinson’s
- ☐ Peripheral Neuropathy
- ☐ PTSD
- ☐ Pulmonary Embolism
- ☐ Pulmonary Fibrosis

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PAST MEDICAL HISTORY CONT.
Please mark all conditions that you have or have had.

- ☐ Bipolar Disorder
- ☐ Bleeding Disorder
- ☐ Blood Clots / DVT
- ☐ Blood Disease
- ☐ Cancer
- ☐ Cataracts
- ☐ Chronic Pain
- ☐ Claustrophobic
- ☐ Colitis / Crohn's
- ☐ COPD/Emphysema
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Gastritis
- ☐ GERD (Acid Reflux)
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart Attack (MI)
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Heart Valve Problems
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hernia - Hiatal
- ☐ Hernia - Inguinal
- ☐ Irregular Heartbeat / Palpitations
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Macular Degeneration
- ☐ Melanoma
- ☐ Migraines
- ☐ MRSA
- ☐ Recurrent Skin Infections
- ☐ Recurrent UTI
- ☐ Retinal Detachment
- ☐ Seizures / Epilepsy
- ☐ Sexual Dysfunction
- ☐ Shingles
- ☐ Sleep Apnea
- ☐ Sexually Transmitted Disease (STD)
- ☐ Stroke / TIA
- ☐ Substance Abuse
- ☐ Tuberculosis
- ☐ Ulcer

If any of the above are checked, please briefly explain and give approximate dates diagnosed.

____
____
____
____
____

Is there any other information regarding your past medical history that we should know about?

____
____
____
____

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Age of first menstrual period: ________________
Date of last menstrual period or age of menopause: ________________
Do you have any future plans to get pregnant?

- ☐ Yes, I want to become pregnant
- ☐ I'm OK either way
- ☐ No, I don't want to become pregnant
- ☐ Unsure

Pregnancy History (If Applicable)

- ☐ Pregnancies #: _____
- ☐ Births #: _____
- ☐ Cesarean section #: _____
- ☐ Miscarriages #: _____
- ☐ Abortions #: _____

DELIVERY DATE	NAME OF CHILD	COMPLICATIONS
________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________

PAST SURGICAL HISTORY

SURGERY	YEAR	HOSPITAL
________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________

IMPLANT HISTORY

If you have a pacemaker, please include your pacemaker barcode.

IMPLANT	YEAR PLACED	HOSPITAL
________________	________________	________________
________________	________________	________________
________________	________________	________________

VACCINE HISTORY

VACCINE	DATE(S) GIVEN	ADMINISTERED BY (i.e. clinic name/number, pharmacy name/number, etc.)
COVID-19	1. ________ 2. ________	________________ ________________
Influenza		
Hepatitis A	1. ________	________________
Hepatitis A Cont.	2. ________ 3. ________	________________ ________________
Hepatitis B	1. ________ 2. ________ 3. ________	________________ ________________ ________________
Human Papillomavirus (HPV)	1. ________ 2. ________	________________ ________________

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Meningococcal	1. ____________ 2. ____________	________________ ________________
Measles, Mumps, Rubella (MMR)	1. ____________ 2. ____________	________________ ________________
Pneumococcal (Pneumonia)	1. ____________ 2. ____________	________________ ________________
Polio	1. ____________ 2. ____________ 3. ____________ 4. ____________	________________ ________________ ________________ ________________
RSV		
Tdap		
Varicella (Chickenpox)	1. ____________ 2. ____________	________________ ________________
Zoster (Shingles)	1. ____________ 2. ____________	________________ ________________

TESTING / EXAM HISTORY

TEST	DATE OF LAST TEST / EXAM	WHERE
Colonoscopy	____________	________________
CT Calcium Score (Coronary Artery Scan)	____________	________________
Bone Density (DEXA)	____________	________________
Breast Exam (Women Only)	____________	________________
Breast MRI	____________	________________
Breast Ultrasound	____________	________________
Dental Exam	____________	________________
Eye Exam	____________	________________
Mammogram	____________	________________
PAP Smear (Women Only)	____________	________________
PSA Test (Men Only)	____________	________________
Skin Exam	____________	________________

Please list details of any other screening scans or testing, as applicable (i.e., Abdominal Aortic Aneurysm [AAA] screening, carotid artery screening, lung cancer screening CT, etc.).

____

____

____

____

PROVIDERS YOU ARE SEEING

Please list the providers and clinics you are currently seeing or have seen in the past, the reason for seeing them, and phone number.

REVIEW OF SYSTEMS

Please mark if you currently have or have had within the last few weeks any of the symptoms below.

GENERAL
☐ Abnormal bleeding
☐ Abnormal bruising
☐ Chills
☐ Cold intolerance
☐ Dizziness
☐ Fainting episodes
☐ Fatigue
☐ Fever
☐ Flushing
☐ Heat intolerance
☐ Insomnia
☐ Loss of appetite
☐ Lymph node enlarged
☐ Night sweats
☐ Sleep disturbance
☐ Weight gain
☐ Weight loss

EYES
☐ Blurry vision
☐ Double vision
☐ Dry eyes
☐ Eye discharge
☐ Eye pain
☐ Floaters
☐ Light sensitivity
☐ Vision loss

EAR, NOSE, & THROAT
☐ Bleeding gums
☐ Earache
☐ Ear discharge
☐ Hearing loss
☐ Hoarseness
☐ Mouth ulcers
☐ Nasal congestion
☐ Nosebleeds
☐ Ringing in the ears
☐ Seasonal allergies
☐ Sore throat
☐ Vertigo or room spins

HEART
☐ Arm pain with exercise
☐ Chest discomfort/pain
☐ Difficulty breathing at night
☐ Exercise intolerance
☐ Leg cramps with exercise
☐ Lightheaded
☐ Palpitations/racing heart
☐ Short of breath with exercise
☐ Swelling (legs or feet)

LUNGS
☐ Breathing problems
☐ Cough
☐ Coughing up blood
☐ Coughing up mucus
☐ Short of breath
☐ Snoring
☐ Wheezing

GASTROINTESTINAL
☐ Abdominal pain
☐ Black tarry stools
☐ Bloating
☐ Bloody stools
☐ Change in bowel habits
☐ Diarrhea
☐ Gas, excessive
☐ Heartburn & indigestion
☐ Hemorrhoids
☐ Nausea
☐ Swallowing difficulty
☐ Swallowing pain
☐ Vomiting
☐ Vomiting blood
☐ Yellow skin/eyes color

ENDOCRINE
☐ Skin color has changed
☐ Sweating, excessive
☐ Thirst, excessive
☐ Unusual hair distribution

URINARY
☐ Blood in urine
☐ Cloudy urine
☐ Inability to control bladder
☐ Inability to empty bladder
☐ Frequent urination
☐ Lack of sexual drive
☐ Nighttime urination
☐ Burning/painful urination
☐ Urinary urgency
☐ Weak urinary stream

MUSCLES & JOINTS
☐ Back pain
☐ Joint pain
☐ Joint swelling
☐ Morning joint stiffness
☐ Muscle cramps/pain
☐ Muscle weakness

SKIN
☐ Change in moles
☐ Excessive dry skin
☐ Hair loss
☐ Hives
☐ Itching
☐ Nail changes
☐ Rash
☐ Skin cancer
☐ Sores, non-healing

NEUROLOGY
☐ Difficulty concentrating
☐ Falls
☐ Headaches
☐ Memory loss
☐ Numbness or tingling
☐ Paralysis
☐ Poor balance
☐ Seizures
☐ Speech difficulty
☐ Tremors
☐ Weakness

PSYCHIATRY
☐ Anxiety
☐ Depression
☐ Hallucinations
☐ Mania
☐ Substance abuse
☐ Suicidal thoughts
☐ Violent thoughts

MEN ONLY
☐ Erection problems
☐ Lump in testicle
☐ Penis discharge
☐ Penis pain
☐ Sore on penis
☐ Testicle pain

WOMEN ONLY
☐ Breast lump
☐ Breast pain
☐ Heavy periods
☐ Hot flashes
☐ Irregular periods
☐ Nipple discharge
☐ Painful intercourse
☐ Painful periods
☐ Pelvic pain
☐ Post menopausal bleeding
☐ Vaginal burning
☐ Vaginal discharge
☐ Vaginal itching
☐ Vaginal sores

FAMILY HISTORY

Family Member - please include names and ages	Alive? If deceased, please include cause of death, if known	Significant Medical History - please include age of diagnosis, if known
Maternal Grandmother	☐ Yes ☐ No	
Maternal Grandfather	☐ Yes ☐ No	
Paternal Grandmother	☐ Yes ☐ No	
Paternal Grandfather	☐ Yes ☐ No	
Mother	☐ Yes ☐ No	
Father	☐ Yes ☐ No	
Aunt(s)	☐ Yes ☐ No	
Uncle(s)	☐ Yes ☐ No	
Brother(s)	☐ Yes ☐ No	
Sister(s)	☐ Yes ☐ No	
Kid(s)	☐ Yes ☐ No	

NUTRITION

Do you follow a special diet? ____
____
____
____

What do you eat for breakfast? ____
____
____
____

What do you eat for lunch? ____
____
____
____

What do you eat for dinner? ____
____
____
____

How much water do you drink daily? ________ ounces

Do you snack--how often? ____
____
____
____

How many grams of protein do you eat daily? ________ grams

EXERCISE

How many days a week do you exercise? _______
How many minutes per week do you do cardio? _______
How many days a week do you strength train? _______
Are you happy with your exercise capacity? ☐ Yes ☐ No
Do you consider yourself an athlete? ☐ Yes ☐ No
What type of exercise do you enjoy? ____
____
____

Are you training for anything? ____
____
____

SLEEP

How many hours do you sleep each night? _______
Do you take anything to sleep? ____
Do you feel rested when you wake up? ☐ Yes ☐ No
Do you snore? ☐ Yes ☐ No
Do you get up in the middle of the night? ☐ Yes ☐ No
Any restless leg syndrome? ☐ Yes ☐ No
Do you wear a CPAP/BIPAP? ☐ Yes ☐ No

RELIGION
Do you have any religious preferences? ____
____
____

EMOTIONAL HEALTH

Do you feel depressed? ☐ Yes ☐ No
Do you feel anxious? ☐ Yes ☐ No
What are the biggest stressors in your life? ____
____
____
____

MARRIAGE AND SEXUALITY

Relationship status: ☐ Married ☐ Domestic Partner ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Do you feel safe in your relationship? ☐ Yes ☐ No ☐ Prefer Not to Answer
Are you sexually active? ☐ Yes ☐ No
Which partner(s) are you sexually active with? ☐ Same Partner ☐ New Partner ☐ Multiple Partners
What gender(s) are your sexual partner(s)? ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Nonbinary ☐ Multiple Genders
Do you use condoms during sex? ☐ Yes ☐ No
Other birth control or STD protection used: ____
Are you interested in being screened for STD's? ☐ Yes ☐ No

WORK/HOME

Who lives with you at home? ______________________________

Do you feel safe at home? ☐ Yes ☐ No

What do you do for a living?______________________________

Do you have children? Please include their names and ages. ______________________________

____

____

Do you have grandchildren? ☐ Yes ☐ No

Do you have animals at home? ☐ Yes ☐ No

Do you live in Colorado full time? If not, where else do you live and when? Y / N ___________

____

When do you plan on retiring? ______________________________

Do you have a basement? ☐ Yes ☐ No If yes, has your home been tested for radon or include a radon mitigation system? ☐ Yes ☐ No

Do you have smoke and carbon monoxide detectors in your home? ☐ Yes ☐ No

Are you passively exposed to smoke? ☐ Yes ☐ No

Are there any smokers in your house? ☐ Yes ☐ No

Are there any guns present in your home? ☐ Yes ☐ No

What is the fluoride status of your home? ☐ Fluoridated ☐ Non-fluoridated ☐ Unknown

What type of noise exposure are you exposed to? ☐ No exposure to excessive noise ☐ Industrial ☐ Firearm ☐ Explosions or blasts ☐ Other ______________________________

Have you been exposed to chemicals or toxins? ☐ Yes ☐ No

Have you been exposed to heavy metals? ☐ Yes ☐ No

HEALTH GOALS

What are your health goals for the next:

6 months: ______________________________

____

____

____

1 year: ______________________________

____

____

____

5 years: ______________________________

____

____

____

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10 years: ____

____

____

____

HABITS

Tobacco

Do you or have you ever used tobacco? ☐ Never used ☐ Former user ☐ Current user

- ☐ Cigarettes - _____ packs / day
- ☐ Chew - _____ / day
- ☐ Cigars - _____ / day
- ☐ # of years _____ or year quit _____

Do you or have you ever used e-cigarettes or vape? ☐ Never used ☐ Former user ☐ Current user

- ☐ # of years _____ or year quit _____

Do you or have you ever used any nicotine-free cigarettes, vape, or chewing tobacco? ☐ Yes ☐ No

Drugs

Do you currently use any recreational or illicit drugs? ☐ Yes ☐ No If yes, list: ____________

____

Alcohol

Do you drink alcohol? ☐ Yes ☐ No

How many times per week do you consume alcohol? ☐ < 1 time per week ☐ 1-2 times per week ☐ 3-4 times per week ☐ 5-7 times per week

How many alcoholic drinks do you consume per day on average? ___________________

Caffeine

How would you describe your caffeine intake? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

# of cups / cans per day? _______

Soft Drinks

How would you describe your soft drink intake? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

# of cups / cans per day? _______

Sweets

How would you describe your intake of sweets? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Please list the sweets you eat and how often: ____

____

Lifestyle

Do you wear a seat belt routinely? ☐ Yes ☐ No

Do you wear a helmet when biking? ☐ Yes ☐ No

Do you use insect repellent routinely? ☐ Yes ☐ No

Do you use sunscreen routinely? ☐ Yes ☐ No

Activities of Daily Living

Are you able to care for yourself? ☐ Yes ☐ No

Are you blind or do you have difficulty seeing? ☐ Yes ☐ No

Are you deaf or do you have serious hearing difficulty? ☐ Yes ☐ No

Do you have difficulty concentrating, remembering, or making decisions? ☐ Yes ☐ No

Do you have difficulty walking or climbing stairs? ☐ Yes ☐ No

Do you have difficulty dressing or bathing? ☐ Yes ☐ No

Do you have difficulty doing errands alone? ☐ Yes ☐ No

Are you able to walk? ☐ Yes: without restriction ☐ Yes: with assistive device(s) ☐ Yes: limited mobility with assistive device(s), generally relies on wheeled mobility ☐ No: unable to walk

Do you have transportation difficulties? ☐ Yes ☐ No