We would like to ask you a few more questions to better understand your health care needs. Please circle the answer that applies to you.

How do you rate your health?	Very unhealthy	Unhealthy	Average health	Healthy	Very healthy
Over the last year, how satisfied have you been with your health care?	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
In the past year, how many times have you been treated in an Emergency Room?	5 or more		2-4	0 or 1	
In the past year, how many times have you been hospitalized?	3 or more		2	0 or 1	

We would like to know about your experience with past medical care. Thank you so much.

I had one person that I thought of as my personal doctor or nurse.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
It was easy for me to get medical care when I needed it.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Most of the time, when I visited my doctor's office, it was well-organized, efficient, and did not waste my time.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The information given to me about health problems was very good.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I am confident that I can manage and control most of my health problems.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

Other comments or suggestions:

SWEDISH FAMILY MEDICINE – BALLARD
1801 N.W. Market St., Suite 403
Seattle, WA 98107

www.swedish.org

SWEDISH

SWEDISH FAMILY MEDICINE – BALLARD

Health History Questionnaire

Sticker	

Preferred Name or Nickname *(if different)*	**Previous Primary Care Provider (PCP)**
Gender *(preferred pronoun)*	**Last visit to PCP:**
Primary Language *(if different from English)*	**Reason for changing provider**
Reason for visit today/ Primary Concern	

ALLERGIES to medications	☐ **No known allergies**
Name of Drug or Substance	Reaction You Had and When

MEDICATIONS List prescribed and over-the-counter drugs, such as vitamins, pain medications, nasal sprays and inhalers

Name of Drug and Dose	How often and when	Reason

MEDICAL ISSUES List any **medical problems** that other doctors have diagnosed and **year diagnosed**

Diagnosis	Year

SURGERIES

Year	Surgery and reason	Hospital/Surgeon

HOSPITALIZATIONS

Year	Reason	Hospital

Immunizations and dates:

☐ Tetanus ☐ Tdap ☐ Pneumonia ☐ Hepatitis B
☐ Chickenpox ☐ Influenza ☐ MMR

FAMILY HEALTH HISTORY

Status of family members	Mother	Father	Sister(s)	Brother(s)	Children
Living (age)					
Deceased (age at death)					

Circle and indicate the diseases that your **family members** have below
☐ Adopted ☐ Unknown family history ☐ Negative family history

Condition	Family member /side of family (maternal, paternal)/ age	Condition	Family member /side of family (maternal, paternal)/ age
Alcohol / Drug		High blood pressure	
Allergies/Eczema		Lung (Asthma, COPD)	
Alzheimer's or other Dementia		Mental Illness/ Anxiety/Depression	
Autoimmune/ Rheumatological		Neurological (Brain, Nerves)	
Cancer		Sickle Cell/ other blood disorders	
Diabetes		Stroke	
Gastrointestinal		Thyroid	
Kidney, bladder		Other	
Heart disease/ heart attack			

HEALTH HABITS AND SOCIAL HISTORY			
Relationship status: ☐ Single ☐ Married/partnered ☐ Separated ☐ Divorced ☐ Widowed			
Who lives with you at home? Names and relationships:			
Housing situation: Stable housing? ☐ Yes ☐ No			
Highest education level	Current occupation (if retired, past occupation): Are you satisfied your current job: ☐ Yes ☐ No		
Physical Activity	How many times a week do you exercise? How many minutes each time?		
	Type of activities:		
Diet	Describe your diet:		
Alcohol	How often do you have a drink containing alcohol? ☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ >4 times a week How many drinks do you have on a typical day? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more How often do you have 6 or more drinks on one occasion? ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily		
Tobacco	☐ Current smoker _____ pks/day # of years _____ ☐ Interested in quitting ☐ Former smoker _____ pks/day # of years _____ quit date: _____ ☐ Other forms of tobacco (ie chew, vape) and frequency of use		
Drugs	Do you currently use recreational or street drugs like heroin, marijuana, oxycodone, or methamphetamine? If so, what type?	☐ Yes	☐ No
	If you are not currently using, have you ever had dependence/ problems with drugs? If so, what type?	☐ Yes	☐ No
	Have you ever injected drugs?	☐ Yes	☐ No
Sex	Are you sexually active? Partners: ☐ Men ☐ Women ☐ Both Numbers of partners in the past year: _____	☐ Yes	☐ No
	What are you doing to prevent getting a sexually transmitted disease?		
	What are you doing to prevent pregnancy? If no contraceptive, are you trying to become pregnant?	☐ Yes	☐ No
	Have you ever had any sexually transmitted infections?	☐ Yes	☐ No
Advanced Directive	Do you have a living will or advanced directive?	☐ Yes	☐ No

WOMEN ONLY	
Age at onset of menstruation: Start date of your last menstrual period?	Period every _____ days lasting _____ days
Have you ever been pregnant? ☐ Yes ☐ No # of pregnancies _____ # of live births _____ # of abortions _____ # of miscarriages including ectopic _____ # of living children _____	
Are you postmenopausal? ☐ Yes ☐ No	If yes, what age?
Date of last pap smear?	History of abnormal? When? Any procedures like biopsy or LEEP?
Date of last mammogram:	History of abnormal? When?

MENTAL HEALTH		
During the past 2 weeks, have you been bothered by: feeling down, depressed, or hopeless? ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day		
During the past 2 weeks, have you been bothered by: having little interest or pleasure in doing things? ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day		
During the past 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge? ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day		
During the past 2 weeks, how often have you been bothered by not being to control or stop worrying? ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day		
Have you ever seriously considered or attempted suicide?	☐ Yes	☐ No

REVIEW OF SYSTEMS- WHAT SYMPTOMS ARE YOU CURRENTLY HAVING?					
General			**Musculoskeletal**		
☐ Fevers ☐ Chills	☐ Night sweats ☐ Fatigue	☐ Weight loss ☐ Weight gain	☐ Stiff/painful joint	☐ Joint swelling ☐ Weakness	☐ Poor range of motion
Eyes			**Skin/Breast**		
☐ Eye pain ☐ Eye irritation	☐ Vision loss ☐ Floaters	☐ Blurry vision ☐ Headache	☐ Changing moles ☐ Dry skin	☐ Rash ☐ Breast pain	☐ Breast lump ☐ Nipple discharge
Ears/Nose/Mouth/Throat			**Neurological/Psych**		
☐ Ringing in ears ☐ Hearing loss	☐ Runny nose ☐ Sinus pain	☐ Toothache ☐ Sore throat	☐ Seizure ☐ Passing out	☐ Numbness ☐ Tingling	☐ Anxiety ☐ Sleep problem
Cardiovascular			**Endocrine**		
☐ Chest pain ☐ Palpitations	☐ Hard to breathe lying down	☐ Leg swelling	☐ Appetite change ☐ Increased thirst	☐ Low energy	☐ Hot/Cold Intolerance
Respiratory			**Hematologic/Lymph**		
☐ Short of breath ☐ Cough	☐ Wheezing ☐ Hard to exercise	☐ Blood in cough ☐ Sputum	☐ Easy bruise/ bleed	☐ Bleeding gums	☐ Swollen lymph nodes
Gastrointestinal			**Genitourinary**		
☐ Hard to swallow ☐ Abdominal pain	☐ Nausea/Vomit ☐ Diarrhea	☐ Constipation ☐ Blood in stool	☐ Urinary pain ☐ Blood in urine ☐ Frequent urination ☐ Pain with sex/ concerns	☐ Vaginal discharge ☐ Abnormal/ painful menstruation	☐ Erectile dysfunction ☐ Weak stream ☐ Penile discharge
Other					