Valley Care Clinics
The care you need, when you need it

HEALTH HISTORY QUESTIONNAIRE

Name: _____ ___M ___ F DOB: _____ Date: _____

Martial Status/Estado Civil: ☐ Single/Soltero/a ☐ Partnered/Con Pareja ☐ Married/ Casado/a ☐ Seperated/Separado/a ☐ Divorced/Divorciado/a ☐ Widowed/Viudo/s	
Previous or Referring doctor/Medico anterior:	Date of Last Physical/Ultimo examen fisico:

PERSONAL HEALTH HISTORY/ HISTORIAL PERSONAL DE SALUD

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken pox ☐ Rheumatic Fever ☐ Polio

Immunizations and date/Fecha de vacunacion	☐ Tetanus	☐ Hepatitis	☐ Influenza	☐ Up to date
	☐ Pneumonia	☐ Chickenpox	☐ MMR Measles,Mumps,Rubella	

List any medical problems that other doctor have diagnosed/Problemas diagnosticados

Surgeries/Operaciones:			**Other hospitalizations/Hospitalizaciones:**		
Year/Ano:	Reason/Razon	Hospital	Year/Año	Reason/Rason	Hospital

Have you ever had a blood transfusion?/ Ha tenido alguna transfucion de sangre? ☐ **Yes** ☐ **No**

List your prescribe and over the counter medication/Lista de Medicamentos			**Allergies to Medication/Alergias a medicamentos**	
Name the Drug/Nombre de medicamento	Strength/Dosis	Frequency Taken/Frecuencia	Name/Nombre	Restion/reacion

HEALTH HABITS AND PERSONAL SAFETY/HABITOS PERSONALES

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFINDENTIAL

Exercise/Ejercicio	☐ Sedentary (No exercise)/Nada de ejercicio ☐ Mild Exercise (i.e. climb stairs, walk 3 blocks, golf)
	☐ Occasional vigorous exercise (less than 4x/week for 30 minutes)/Menos de 4 veces por semana
	☐ Regular vigorous exercise (4x/week for 30 minutes) /Ejercicio regular 4 veces por semana
Diet/Dieta	Are you dieting? / Esta en dieta? ☐ Yes ☐ No……#of meals you eat in an average day? / Cuantas comidas da al dia?
	If yes, are you on a physician prescribed medical diet? Es dieta recetada por algun medico? ☐ Yes ☐ No
	Rank of Salt/Consumo de Sal ☐ Hi/Alto ☐ Med/Moderado ☐ Low/Bajo
	Rank fat intake/Consumo de grase ☐ Hi/Alto ☐ Med/Moderado ☐ Low/Bajo
Caffeine/Cafeina	☐ None/Nade ☐ Coffee/Café ☐ Tea/Te ☐ Cola/Coca……. # of cups per day?/Cuantas tazas por dia?
Alcohol	Do you drink alcohol? /Toma alcohol? ☐ Yes ☐ No…… If yes, what kind?/Tipo?
	How many drinks per week?/ Cantidad por semana?
	Are you concerned about the amount you drink?/ Le preocupa la cantidad? ☐ Yes ☐ No
	Have you Considered stopping? / Ha considerado defarlo? ☐ Yes ☐ No
	Have you ever experienced blackouts? Alguna ves ha sufrido desmayo? ☐ Yes ☐ No
	Are you prone to “binge” drinking?/ Esta propenso a borrachera? ☐ Yes ☐ No
	Do you drive after drinking?/ Maneja despues de tomar? ☐ Yes ☐ No
Tobacco	Do you use tobacco?/ Usa tabaco ☐ Yes ☐ No
	☐ Cigarettes – pks/day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day ☐ # of years ☐ Or year quit
Drugs/Drogas	Do you currently use recreational or street drugs? / Usa drogas ilegales? ☐ Yes ☐ No
	Have you ever given yourself street drugs with a needle? / Ha inyectado drogas? ☐ Yes ☐ No

Sex/Sexo	Are you sexually active? / Es sexualmente active?	☐ Yes ☐ No
	If yes, are you trying for a pregnancy?/ Esta tratando de embarazarse?	☐ Yes ☐ No
	If not trying for a pregnancy list contraceptive or barrier method used/ Contraceptivo:	
	Any discomfort with intercourse?/ Tiene dolor con las relaciones?	☐ Yes ☐ No
	Would you like to speak with yur provider about your risk of HIV?/Le gustaria hablar con el medico acerca de su riesgo de VIH?	☐ Yes ☐ No
Personal Safety Seguridad Personal	Do you live alone? /Vive solo? ☐ Yes ☐ No	Do you have frequent falls? / Ha sufrido caidas resiente? ☐ Yes ☐ No
	Do you have vision or hearing loss? /Tiene problemas para ver o oir?	☐ Yes ☐ No
	Do you have an Advance Directive and or Living Will? / Tiene Directivas Avanzadas o testament?	☐ Yes ☐ No
	Would you like information on the preparation of these? / Le gustaria informacion?	☐ Y ☐ No
	Would you like to discuss physical, sexual or mental abuse with your provider?/ Le gustaria hablar con el medico acerca de abuso fisco, sexual o emocional?	☐ Yes ☐ No

FAMILY HEALTH HISTORY/HISTORIA FAMILIAR

	AGE/EDAD	HEALTH PROBLEMS/PROBLEMAS DE SALUD		AGED/EDAD	HEALTH PROBLEMS/PROBLEMAS DE SALUD
Father/Padre			**Children/ Hijos**	☐M ☐F	
Mother/Madre					
Sibling/ Hermanos/as	☐M ☐F			☐M ☐F	
	☐M ☐F			☐M ☐F	
	☐M ☐F		**Grandmother Maternal/Abuela ma**		
	☐M ☐F		**Grandfather Maternal/Abuelo ma**		
	☐M ☐F		**Grandmother Paternal/Abuela pa**		
	☐M ☐F		**Grandfather Paternal/Abuelo pa**		

MENTAL HEALTH/SALUD MENTAL

Is Stress a major problem for you? /Es el estres problema mayor para usted? ☐ Yes ☐ No	Do you feel depressed?/Se siente deprimido? ☐ Yes ☐ No
Do you panic when stressed?/Se atemoriza cuando se estresa? ☐ Yes ☐ No	Do you cry frequently?/Llora con frecuencia? ☐ Yes ☐ No
Do you have trouble sleeping?/Tiene problema para domir? ☐ Yes ☐ No	Have you ever been to a counsler?/Ha ido con algun consejero? ☐ Yes ☐ No
Do you have problems with eating or your appetite?/ Tiene problema con su apetito? ☐ Yes ☐No	
Have you ever seriously thought about hurting yourself? / Alguna vez ha pensado en danarse? ☐ Yes ☐ No	
Have you ever attempted suicide?/alguna vez ha intentado el suicidio? ☐ Yes ☐ No	

CHECK IF YOU HAVE, OR HAVE HAD ANY SYMPTOMS IN THESE AREAS/MARQUE SOLO SI TIENE O HA TENIDO SINTOMAS EN ESTA AREAS

☐ Skin/Piel	☐ Lungs/Pulmones	☐ Head/Neck:Cabeza/Cuello	☐ Recent changes in/Cambios recientes:
☐ Ears/Oidos	☐ Bowel/Escremento	☐ Circulation/Circulacion	
☐ Nose/Nariz	☐ Bladder/Vejiga	☐ Chest/Heart;Pecho/Corazon	☐ Other pain/discomfort/Algun otro dolor o molestia:
☐Weight/Peso	☐ Throat/Garganta	☐ Energy Level/Nivel de energia	
☐ Back/Espalda	☐ Intestinal/Intestino	☐ Ability to sleep/Abilidad de dormir	

WOMEN ONLY	**MEN ONLY**
Age at onset of menstruation?/Edad de Primera menstracion?	Do you usually get up to urinate during the night/Se levanta a orinad de noche? ☐ Yes ☐No
Any blood in the urine? Ha tenido sanrgrado en la orina? ☐ Yes ☐ No	If yes # of times/cuantas veces:
Date of last menstruation/Fecha de su ultima menstracion:	Do you feel pain or burning with urination? Siente dolor o ardor al orinar? ☐ Yes ☐ No
Period every how many days? Regla cada cuantos dias?	Any blood in the urnine? Tiene sangre en la orina? ☐ Yes ☐ No
Heavy periods, irregularity, spotting, pain or discharge? Tiene reglas pesadas, irregular/dolor o deschcho? ☐ Yes ☐ No	Do you feel burning discharge from penis? Siente ordor en el pene? ☐ Yes ☐ No
Number of pregnancies/Numero de embarazos? Number of live births/Numero de nacimientos	Has the force of your urination decreased? Se ha disminuido la fuerza de la orina? ☐ Yes ☐ No
Are you pregnant or breastfeeding? Esta embarazada o dando pecho? ☐ Yes ☐ No	Do you have any problems emptying your bladder?/Tiene problemas vaciando su vejiga completamente? ☐ Yes ☐No
Have you had a D&C, hysterectomy, or Cesarean? Ha tenido un raspado, histerectomia, o cesaria? ☐ Yes ☐ No	Any difficulty with erection or ejaculation? Ha tenido problemas con ereccion o eyaculacion? ☐ Yes ☐ No
Any urinary tract, bladder, or kidney infections within the last year? Ha tenido alguna infection de orina o del rinon en este ano? ☐ Yes ☐ No	Any testicle pain or swelling? Ha tenido dolor o hinchazon en los Testioculos? ☐ Yes ☐ No
Any problems with control or urination? Ha tenido problemas controlando la orina? ☐ Yes ☐ No	Date of last prostate and recatal exam? Fecha de su ultimo examen rectal y postata?
Any hot flashes or sweating at night? Ha tenido calores o sudor de noche? ☐ Yes ☐ No	Have you had any kidney, bladder, or prostate infections within the last 12 months? /Ha tenido infeccion en la vejiga, rinon, o prostate en los ulimos 12 meses? ☐ Yes ☐ No
Date of last pap and rectal exam? Fecha de su ultimo papanicolau y examen rectal?	Comments:
Experienced any breast tenderness, lumps, or nipple discharge? Ha tenido dolor, bolitas o deshecho del peson? ☐ Yes ☐ No	
Do you have any menstrual tension,pain,bloating,irritability at or around time of periods?/Tiene dolor,inflamacion,irritabilidado malestar en su regal? ☐ Yes ☐ No	