1919 Lathrop St. Suite 222
Fairbanks, AK 99701

Health Questionnaire

Full Legal Name: _____ Today's Date: _____

Preferred Name: _____ Pronouns: _____ Date of Birth: _____

Sex: ☐ Female ☐ Male ☐ Intersex Primary Care Provider: _____

Reason for today's visit: _____

	Year of Last		Year of Last
Total Physical		Bone Scan (DEXA)	
Pap Smear		HPV Vaccine	
Mammogram		Flu Vaccine	
Colonoscopy		COVID vaccine (type)	

Please list all medications you are currently taking. Include vitamins, supplements and medications; including prescriptions, inhalers, and over-the-counter drugs.

Drug Name	Strength	Frequency Taken
1.		
2.		
3.		
4.		
5.		

Please check to indicate if you have ever had the following conditions:

☐ Anxiety Disorder	☐ Emphysema	☐ Obesity
☐ Arthritis	☐ Eye Problems, Type: _____	☐ Pulmonary Embolism
☐ Asthma	☐ Fibromyalgia	☐ Reflux or ☐ Ulcers
☐ Allergies or Hay fever	☐ Gout	☐ Seizures
☐ Anemia or ☐ Blood Transfusion	☐ Headaches or ☐ Migraines	☐ Sexually Transmitted Infections
☐ Bleeding Disorder	☐ Heart Attack	☐ Skin Disease or Chronic Rashes
☐ Blood Clots/DVT	☐ Heart Murmur	☐ Stroke
☐ Cardiac Arrhythmia or Pacemaker	☐ HIV or AIDs	☐ Substance Use Disorder
☐ Congestive Heart Failure	☐ High Cholesterol	☐ Thyroid Disease
☐ Coronary Artery Disease	☐ High Blood Pressure	☐ Tuberculosis
☐ Depression	☐ Insomnia	☐ Unhealthy Alcohol Use
☐ Diabetes	☐ Kidney Disease	☐ Cancer, Type:
☐ Dialysis	☐ Kidney Stones	_____
☐ Diverticulitis	☐ Liver Disease or Hepatitis	☐ Other, Please Explain:
☐ Eating Disorder	☐ Osteoporosis	_____

List Medication Allergies or Reactions: If no allergies check ☐ NONE

Medication Allergy	Reaction
1.	
2.	
3.	

1919 Lathrop St. Suite 222
Fairbanks, AK 99701

Patient Name: _____ Today's Date: _____

Please list any surgeries or overnight hospital stays:

Type of surgery/reason for hospitalization	Reason	Date or Approx Year
1.		
2.		
3.		

Reproductive Health

Menstrual Cycle: ☐ Monthly ☐ Irregular ☐ Pain/Cramps ☐ Absent Since _____
First Day of Last Cycle: _____ Days of Bleeding: _____ # of Days between Cycles: _____
Pregnancies: _____ Miscarriages: _____ Induced Abortions: _____ Living Children: _____

Any History of Abnormal Pap Smears? ☐ Yes ☐ No
If yes, what type? ☐ ASCUS, Atypical squamous cells of undetermined significance
☐ ASC-H, Atypical squamous cells, cannot exclude high-grade squamous intraepithelial lesion
☐ LSIL, Low-grade squamous intraepithelial lesion ☐ HSIL, High-grade squamous intraepithelial lesion
☐ HPV Positive ☐ Unsure
What Year? _____
Are you planning on becoming pregnant in the next year? ☐ Yes ☐ No

Social History

Do you smoke or use any tobacco products?
☐ Yes ☐ No ☐ Quit
Number of cigarettes each day? _____
For how many years? _____

Do you use other nicotine products?
☐ Yes ☐ No ☐ Quit

Do you vape? ☐ Yes ☐ No ☐ Quit
What active ingredient? _____
How much? _____ How often? _____

Do you use marijuana? ☐ Yes ☐ No ☐ Quit
How much? _____ How often? _____

Do you regularly use other drugs?
☐ Yes ☐ No ☐ Quit
Type of other drugs used _____

Exercise Routine: _____
Dietary Restrictions/Concerns: _____

Any history of Domestic Violence? ☐ Yes ☐ No
Any history of Sexual Abuse? ☐ Yes ☐ No
Do you feel safe at home? ☐ Yes ☐ No
Are you Sexually Active? ☐ Yes ☐ No
If yes, do you engage in: ☐ Oral ☐ Vaginal ☐ Anal Sex
If yes, with: ☐ Men ☐ Women ☐ Both
Do you want STD testing today? ☐ Yes ☐ No

Current Pregnancy Prevention

☐ Birth Control Patch	☐ Nexplanon Implant
☐ Condom	☐ Oral Birth Control
☐ Depo Shot	☐ Tubal Ligation
☐ Diaphragm	☐ Vaginal Ring
☐ IUD	☐ Vasectomy
☐ Natural Family Planning	☐ None

1919 Lathrop St. Suite 222
Fairbanks, AK 99701

Patient Name: _____ Today's Date: _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit

If yes, please complete the following:

Questions	Scoring system					Your Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 9	10+	
How often have you have 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Family History

Check any diseases that run in your family:

	Mother	Father	Sister	Brother	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother	Other
Alcoholism									
Arthritis									
Bleeding Disorder									
Depression									
Diabetes									
Drug Abuse									
Cancer *type: _____									
Genetic Disease									
Heart Attack									
High Blood Pressure									
High Cholesterol									
Mental Illness									
Osteoporosis									
Obesity									
Seizures/Convulsions									
Stroke									
Thyroid Disease									

Please specify if there are any other diseases that run in your family that are not listed:

_____

_____

1919 Lathrop St. Suite 222
Fairbanks, AK 99701

Patient Name: _____ Today's Date: _____

Review of Systems

Have you had any of the following in the last 6 months?

☐ Weight Loss	☐ Frequent Diarrhea
☐ Fever	☐ Nausea/Vomiting
☐ Vision Changes	☐ Heartburn
☐ Sinus Problems	☐ Frequent Constipation
☐ Headaches/Migraines	☐ Blood with Urination
☐ Dizziness	☐ Urine Incontinence/Dribbling
☐ Fainting	☐ Rash/Skin Lésion
☐ Seizures	☐ Discharge from Breasts
☐ Numbness/Nerve Pain	☐ Masses on Skin/Breasts
☐ Frequent Bruises/Easy Bleeding	☐ Pain/Bleeding after Sex
☐ Swelling of Legs	☐ Sexual Problems
☐ Chest Pain	☐ Abnormal Vaginal Symptoms
☐ Heart Palpitations	☐ Hot Flashes
☐ Wheezing/Shortness of Breath	☐ Depression (Crying, Moodiness)
☐ Cough	☐ Anxiety

Other/Additional Information: _____

_____

_____

Personal History

Are you currently married or living with a partner or significant other? ☐ Yes ☐ No

Who lives with you at home? _____

Are you employed? ☐ Yes ☐ No ☐ Retired

If yes, what kind of work do you do? _____

Are you a stay-at-home care giver or homemaker? ☐ Yes ☐ No

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things.	0	1	2	3
Feeling down, depressed, or hopeless.	0	1	2	3