MID-DELTA HEALTH SYSTEMS
HEALTH HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL AND WILL BECOME PART OF YOUR MEDICAL RECORD

NAME (Last, First, MI):_____DOB:_____ Male/Female

E-Mail Address:_____

Previous or Referring Provider:_____

PAST MEDICAL HISTORY (PLEASE CIRCLE ALL THAT APPLY)

Abnormal Mammo	Bipolar Disorder	Diabetes	Heart Murmur	Lupus
Abnormal Pap	Blood Disorder	Diverticulitis	Hepatitis	MI(Heart Attack)
Alcohol Abuse	Cancer(where)	Drug Abuse	High Blood Pressure	Prostate Disorder
Acid Reflux	Cataracts	DVT- Blood Clot	High Cholesterol	Renal Failure (Kidney)
ADHD	CHF Heart failure	Fibromyalgia	HIV	Seizure Disorder
Allergies	Crohns Disease	Glaucoma	Irritable Bowel Synd.	Stroke
Anxiety	Colon Polyp	Gout	Kidney Disease	Thyroid Disorder
Arthritis	COPD	Heart Disease	Liver Disease	Substance abuse: prescription drugs, street or illegal drugs

SURGERIES

YEAR	REASON	HOSPITAL

FAMILY HISTORY (Circle all that apply)

Father	Alive Deceased	Diabetes Hypertension Heart Disease Stroke Depression Anxiety Mental disease Cancer
Mother	Alive Deceased	Diabetes Hypertension Heart Disease Stroke Depression Anxiety Mental disease Cancer
Paternal Grandpa (Father's Side)	Alive Deceased	Diabetes Hypertension Heart Disease Stroke Depression Anxiety Mental disease Cancer
Paternal Grandma (Father's Side)	Alive Deceased	Diabetes Hypertension Heart Disease Stroke Depression Anxiety Mental disease Cancer
Maternal Grandpa (Mother's Side)	Alive Deceased	Diabetes Hypertension Heart Disease Stroke Depression Anxiety Mental disease Cancer
Maternal Grandma (Mother's Side)	Alive Deceased	Diabetes Hypertension Heart Disease Stroke Depression Anxiety Mental disease Cancer
Siblings (brothers or sisters)	Alive Deceased	Diabetes Hypertension Heart Disease Stroke Depression Anxiety Mental disease Cancer
Children	Alive Deceased	Diabetes Hypertension Heart Disease Stroke Depression Anxiety Mental disease Cancer

SOCIAL HISTORY

Family/Household structure:

1. Have you applied and been denied public housing? Yes or No
2. Have you applied and been denied food stamps? Yes or No
3. Are you having problems with your landlord regarding safety issues? Yes or No
4. Have you applied and been denied for WIC, Medicaid, Disability or Social Security or SSI? Yes or No List:_____
5. Who does your support system consist of? (Who do you turn to when you need help) Circle all that apply: Mother, Father, Child, Sibling, Friend, Spouse, Other
6. Family /Household Structure (Circle One): Lives - Alone, with parent, with spouse, with other
7. Do you have legal guardian or health care proxy (someone who can legally make a decision for you if you are unable). Yes or No If Yes, who_____
8. Do you have a Primary care giver(the person who take care of you)? Yes or No If Yes, who_____
9. Do you use drugs illegally? Yes or No
10. Did you have a drink containing alcohol in the past year? Yes or No
11. How many children do you have? _____
12. What is your occupation? _____
13. Do you have hazardous exposures in your occupation? Yes or No
14. Are you exposed to Agricultural chemicals? Yes or No
15. Do you exercise regularly? Yes or No
16. Do you consume caffeine on a daily basis? Yes or No
17. Have you traveled outside the US within the last 6 months? Yes or No

SEXUAL HISTORY

Are you sexually active? Yes or No

LIVING WILL

Do you have any advanced directives or living will? Yes or No

If no, are you interested in learning about advanced directives or living will? Yes or No

LEARNING NEEDS

Do you have problems with vision? Yes or No

Do you have problems with hearing? Yes or No

Do you have problems with reading? Yes or No