HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

☐ High Blood Pressure	☐Depression	☐Acid Reflux	☐ COPD	☐Gout	☐ Stroke
☐ Diabetes	☐ Anxiety	☐Headaches	☐ Seizure	☐Heart Attack	☐ Chronic Pain
☐ Thyroid Problems	☐Arthritis	☐Asthma	☐ Seasonal Allergies	☐Atrial Fibrillation	☐ Dementia

Other Problems:

Surgeries

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.			
Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If yes, what kind?		
	How often? __ daily __ weekly __other		
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day		
	☐ # of years ☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	If yes, what kind? __ Marijuana __Cocaine __Heroin __Other:		
Other	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HISTORY

(PLEASE LIST MEDICAL HISTORY FOR EACH FAMILY MEMBER)

Mother:
Father:
Brother:
Sister:
Maternal Grandmother:
Maternal Grandfather:
Paternal Grandmother:
Paternal Grandfather:

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Date of last mammogram?		
Date of last pap smear?		
Date of last bone density scan?		
Date of last colonoscopy?		

MEN ONLY

Date of last prostate/rectal exam?
Date of last colonoscopy?