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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:**
Previous or referring doctor:	**Date of last physical exam:**

LIST OF PROVIDERS ON YOUR CARE TEAM: (DENTIST, OPTOMETRIST, ETC)

LOCAL PHARMACY (Not your mail order pharmacy)
NAME: _____
ADDRESS: _____
PHONE : _____
FAX: _____

LIST ALL MEDICATIONS (INCLUDING OVER-THE-COUNTER MEDICATIONS)		
Name the Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS	
Name the Drug	Reaction You Had

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
IMMUNIZATIONS AND DATES:	☐ Tetanus:	☐ Pneumonia:
	☐ Hepatitis:	☐ Shingles:
	☐ Influenza:	☐ MMR *Measles, Mumps, Rubella*

MEDICAL HISTORY (Please check all that apply)

☐ Anxiety	☐ Diverticulitis	☐ Last DEXA Scan:_____
☐ Arrhythmia/Tachycardia	☐ Fibromyalgia	☐ Last Mammogram:_____
☐ Arthritis	☐ GERD/Reflux	☐ Last PAP:_____
☐ Asthma	☐ Gout	☐ Liver Disease
☐ Atrial Fib	☐ Heart Disease	☐ Osteoporosis
☐ COPD/Emphysema	☐ High Cholesterol	☐ Pulmonary Embolism
☐ Cancer:_____	☐ High Blood Pressure	☐ Stroke
☐ Coronary Artery Disease	☐ Thyroid Issues	☐ Tuberculosis
☐ Congestive Heart Failure	☐ Kidney Disease	☐ Other pain/discomfort:
☐ Depression	☐ Kidney Stones	
☐ Diabetes: Last retinal exam:_____ Last foot exam:_____	☐ Last Colonoscopy:_____	

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M	

				☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

SOCIAL HISTORY

Occupation:	Retired: Y ☐ N ☐
Do you have: ☐ Living Will ☐ Health Care Surrogate ☐ Do Not Resuscitate	

Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)
Tobacco	Have you ever smoked? Y ☐ N ☐
	If so, how many years have you smoked? _____
	How many packs per day? _____
	Do you use chewing tobacco? Y ☐ N ☐

Alcohol	Do you drink alcohol? Y ☐ N ☐
	If so, how often? (Please circle one) RARE MODERATE HEAVY
	On average, how much do you drink? (i.e. 1 glass per night, 1 liter per week) _____
	Any illicit drug use? Y ☐ N ☐

_____ _____

Signature Date