Original Date:	
Dates Revised:	

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		
Children	☐ Sons-- How Many_____ ☐ Daughters– How Many_____		
Previous or referring doctor:		**Date of last physical exam:**	
Local Pharmacy & City:		**Mail Order Pharmacy:**	
Other Physicians and Healthcare Providers You See?	*List Provider Name and Type of Specialty.*		
1.		**5.**	
2.		**6.**	
3.		**7.**	
4.		**8.**	

PERSONAL HEALTH HISTORY

Immunizations and dates:	☐ **Tetanus** **Approximate Date:**	☐ **Pneumonia** **Approximate Date:**
	☐ **Hepatitis** **Approximate Date:**	☐ **Shingles** **Approximate Date:**
	☐ **Influenza** **Approximate Date:**	☐ **MMR** ***Measles, Mumps, Rubella*** **Approximate Date:**

List All Medical History (Anything not listed please list in other)

☐ Anemia	☐ Blood Clots	☐ Diverticulosis	☐ High Blood Pressure/Hypertension
☐ Asthma	☐ Cancer: Type_____	☐ Emphysema	☐ High Cholesterol
☐ Anxiety	☐ COPD	☐ GERD	☐ Memory Loss
☐ Arthritis	☐ Dementia	☐ Glaucoma	☐ Obesity
☐ Asthma	☐ Depression	☐ Headaches/Migraines	☐ Sleep Apnea
☐ Atrial Fibrillation	☐ Diabetes	☐ Heart Disease	☐ Thyroid Problems

☐ **Other**_____ ☐ **Other** _____

☐ **Other**_____ ☐ **Other** _____

Past Surgeries

Year	Reason/Type of Surgery	Hospital

Other hospitalizations

Year	Reason	Hospital

MEDICATIONS--List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers				
Name the Drug	Strength	Frequency Taken	Dr Who Prescribed It	Start Date
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Allergies to medications & or Food	
Name the Drug/Food	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	Do you Exercise?				☐ Yes	☐ No
	If yes, what kind?					
	How many times per week?					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco or used formerly?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
	Have you considered stopping?				☐ Yes	☐ No
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?				☐ Yes	☐ No
	Would you like information on the preparation of these?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

	DECEASED AT AGE	SIGNIFICANT HEALTH PROBLEMS		DECEASED AT 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*		

WOMEN ONLY

Date of last menstruation:
Are you Post Menospausal?
Date of last pap?
Date of last mammogram?
Date of your last bone density test?
Date of your last colonoscopy?
Date of your last rectal?

MEN ONLY

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

ANY CONCERNS YOU WOULD LIKE TO DISCUSS WITH THE DR TODAY

Permission is hereby granted to healthcare providers within this practice to administer such testing, services, examinations, treatment, and procedures as are deemed necessary in the course of my care. Information about me necessary to substantiate my insurance claims may be released by the healthcare provider in my care. I authorize payment directly to the provider's office of all insurance benefits otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by my insurance, for all services rendered on my behalf or on my dependents.

Signature:_____**Date:**_____