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HEALTH HISTORY QUESTIONNAIRE

Please answer all sections completely and accurately. Information is confidential and will become part of your medical record.

PERSONAL INFORMATION: Please fill in all information and check the appropriate box.

Name:	**Date of Birth:**	**Age:**
Marital Status: ☐**Single** ☐**Divorced** ☐**Partnered** ☐**Widowed** ☐**Married** ☐**Separated**	**Gender:** ☐**Male** ☐**Female**	
Address:	**Phone number:**	

PERSONAL MEDICAL HISTORY: Please check all medical diagnoses that you have had and the date diagnosed.

Abnormal Moles	☐	**Diabetes I (childhood onset)**	☐	**Liver Disease**	☐
Alcohol / Drug abuse	☐	**Diabetes II (adult onset)**	☐	**Migraines**	☐
Allergy (Hay Fever)	☐	**Diverticulosis**	☐	**Osteoporosis**	☐
Anemia	☐	**Eczema**	☐	**Pneumonia**	☐
Anxiety	☐	**Emphysema**	☐	**Prostate (enlargement)**	☐
Arthritis (Rheumatoid)	☐	**Endometriosis**	☐	**Psoriasis**	☐
Arthritis (Osteoarthritis)	☐	**Fibroids**	☐	**Seizure/Epilepsy**	☐
Asthma	☐	**Fractures (Location)**	☐	**Sleep Apnea**	☐
Bladder/Kidney Problems	☐	**Gallbladder Disease**	☐	**Stomach Ulcer**	☐
Blood Clot (leg)	☐	**GERD (acid reflux)**	☐	**Stroke**	☐
Blood Clot (lung)	☐	**Glaucoma**	☐	**STD**	☐
Blood Transfusion	☐	**Gout**	☐	**Thyroid High (Hyperthyroid)**	☐
Breast Lump (benign)	☐	**Heart Attack**	☐	**Thyroid Low (Hypothyroid)**	☐
Cancer (Type)	☐	**Hepatitis (Type)**	☐	**Other:**	☐
Cataracts	☐	**High Blood Pressure**	☐	**Other:**	☐
Colon Polyp	☐	**High Cholesterol**	☐	**Women Only**	
Coronary Artery Disease	☐	**HIV**	☐	**# of Pregnancies**	
COPD	☐	**Irritable Bowel Disease**	☐	**# of Abortions**	
Depression	☐	**Kidney Disease/Failure**	☐	**# of Children Living**	

Please use these lines to fill in additional information pertaining to your personal medical history that may require explanation.

SURGICAL HISTORY: Please check all the surgeries you have had in the past.

Abdominal Surgery	☐	**Ears (Tubes)**	☐	**Ovary (Removal)**	☐
Adenoids Removal	☐	**EGD**	☐	**Sigmoidoscopy**	☐
Appendectomy	☐	**Fibroids (Removal)**	☐	**Sinus Surgery**	☐
Back Surgery	☐	**Gallbladder Removal**	☐	**Tonsils (Removal)**	☐
Biopsy (Location)	☐	**Heart Surgery**	☐	**Tubal Ligation**	☐
Breast Biopsy	☐	**Hip Surgery**	☐	**Vasectomy**	☐
Cataract	☐	**Hysterectomy (Partial)**	☐	**Other:**	☐
Caesarean Section	☐	**Hysterectomy (Total)**	☐	**Other:**	☐
Colonoscopy	☐	**Knee**	☐	**Other:**	☐
Coronary Bypass	☐	**LEEP (Cervix surgery)**	☐	**Other:**	☐
Coronary Stent	☐	**Neck Surgery**	☐	**Other:**	☐

Please use these lines to fill in additional information pertaining to your surgical history that may require explanation.

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IMMUNIZATIONS: Check off any vaccinations you have had. Add year, if known.

Vaccination	Date	Vaccination	Date
Hepatitis A		**Tetanus (Td)**	
Hepatitis B		**With Pertussis (Tdap)**	
Influenza (flu shot)		**Varicella (Chicken Pox)**	
MMR		**Zostavax (shingles)**	
Meningitis		**Other:**	
Pneumovax (pneumonia)		**Other:**	

HEALTH MAINTENANCE SCREENING TESTS: Please place information in the boxes if applicable.

Test	Date	Results	Location
Bone Density Scan			
Colonoscopy			
Eye Exam			
Foot Exam			
Mammogram			
Pap Smear			
Sigmoidoscopy			
Spirometry			
Other:			
Other:			

SOCIAL HISTORY: Please check all that apply and enter dates and amounts when appropriate.

Cigarettes (current)	**☐Y ☐N**	**Packs/day**		**Years Smoked**			
Previous smoker	**☐Y ☐N**	**Packs/day**		**Years Smoked**		**Quit Date:**	
Other Tobacco	**☐Y ☐N**	**Cigar/Pipe**	☐	**Snuff**	☐	**Chew**	☐
Alcohol	**☐Y ☐N**	**Beer**	☐	**Wine**	☐	**Liquor**	☐
# of drinks/week		**Beer:**		**Wine:**		**Liquor:**	
Drug Abuse	**☐Y ☐N**	**Marijuana**	☐	**Cocaine**	☐	**Heroin**	☐
		Prescription drugs	☐	**Other:**	☐	**Other:**	☐
Employed	**☐Y ☐N**	**Type:**		**# of Children**			☐
Exercise	**☐Y ☐N**	**Times/week:**		**How Long:**		**Type:**	
Domestic Violence	**☐Y ☐N**	**Verbal**	☐	**Physical**	☐	**Sexual**	☐

Please use these lines to fill in additional information pertaining to your social history that may require explanation.

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MEDICATIONS: Please list all medications, herbals, and other-the-counter medications that you are taking. If you do not have enough room to complete your medication list please use the additional medication form.

MEDICATION	DOSE	HOW OFTEN	WHO PRESCRIBED?

ALLERGIES: Please list all allergies including food, medications, insects, etc. Please list the reaction.

ALLERGY	REACTION

Thank you for taking the time to complete your health history questionnaire.

ADDITIONAL MEDICATIONS

Please use this form to list any additional medications that were not added to the Health History Questionnaire.

MEDICATION	DOSE	HOW OFTEN	WHO PRESCRIBED?