Date:	

HEALTH HISTORY QUESTIONNAIRE

In an effort to provide you with the best care and treatment possible, please provide us with the following information. All the information you provide is considered confidential and will become part of your medical record. Your records will only be released with your written consent.

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

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever			
Immunizations and dates:	☐ Tetanus		☐ Pneumonia	
	☐ Hepatitis	A/B	☐ Chickenpox	
	☐ Influenza		☐ MMR *Measles, Mumps, Rubella*	

Please check if you, a parent or sibling have ever had any of the following:

	You	Father	Mother	Sibling		You	Father	Mother	Sibling
High Blood Pressure					Alcohol Dependency				
Diabetes					Allergies				
Peptic Ulcers					Glaucoma				
Heart Attack					Asthma				
Chest Pain/Tightness					Bronchitis				
History of Heart Murmur					Pneumonia				
Stroke					Pleurisy				
Cancer					TB				
Hepatitis					GERD				
Yellow Jaundice					Blood in Urine				
Gallstones					Frequent Fractures or Sprains				
Kidney Stones					Arthritis				
Abdominal Bleeding					Dizziness				
Diverticulosis					Sleep Apnea				
Thyroid Problem					Other:				
Lung Problems/Asthma									
Shortness of Breath									
Obesity									
Depression									
Manic-Depressive Disorder									
Schizophrenia									

Please turn to the nest page.

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, foods, dye? _____	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY					
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – packs/day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ No
	Physical and/or mental abuses 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

End of Health History Questionnaire