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:		

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates: Please provide a copy of your record, if available		
	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Prevnar
	☐ Influenza	☐ Tuberculosis Skin Test

Date of last physical exam ________________Date of last EKG _______________Date of last Pap Smear _______________

Date of last Mammogram __________________

Date of last Colon Cancer screening (colonoscopy, flexible sigmoidoscopy or hemocult test) ________________

Have you ever had a blood transfusion? ☐ Y ☐ N

Do you have any of the following medical conditions

Circle	Diagnosis	Date of diagnosis	Circle	Diagnosis	Date of Diagnosis
Y N	Heart Disease		Y N	Bleeding Disorder	
Y N	Abnormal Heart Beat		Y N	Cancer	
Y N	Heart Failure		Y N	Anemia	
Y N	High Blood Pressure		Y N	Clotting disorder	
Y N	Sleep Apnea		Y N	COPD	
Y N	Asthma		Y N	Seizure	
Y N	Anxiety		Y N	Stroke	
Y N	Autoimmune Disorder		Y N	HIV	
Y N	Hepatitis		Y N	Gastrointestinal bleed	
Y N	Depression		Y N	Other	
Y N	Diabetes		Y N	Other	

Surgeries: please indicate if you have had the following surgery

Yes	Surgery	Date
	Hysterectomy	
	Cholecystectomy (Gall bladder)	
	Appendectomy	
	Tonsillectomy	
	Heart Surgery	
	Other (list others surgeries here)	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary	☐ Mild exercise	☐ Occasional vigorous exercise	☐ Regular vigorous exercise
Alcohol	Do you drink alcohol? ☐ Yes ☐ No	If yes, what kind?		☐ How many drinks per week?
Tobacco	Do you use tobacco? ☐ Yes ☐ No		# of years	Or year quit
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
Drugs	Do you currently use recreational or street drugs? What type ________________ How Often _______		☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?		☐ Yes	☐ No
Personal Safety	Employment status ___________________________	Occupation _____________________		
	Do you currently or in the past have you had any dangerous occupational exposures		☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will? Please provide a copy		☐ Yes	☐ No
	Would you like information on the preparation of these		☐ Yes	☐ No

Do you have allergies to any of the following? Include the reaction you had. _______ **No Known Drug Allergies**

Latex	Sulfa
Eggs	Penicillin
Iodine/Shellfish	Keflex/Caphalasporin
Tetracycline	**Other**
Nuts	**Other**

List your prescribed drugs

Name the Drug	**Strength/Dose**	**Frequency Taken**	**Reason**

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

Name the drug/vitamin/herbs	Strength/Dose	Frequency Taken	Reason

FAMILY HEALTH HISTORY

PLEASE INDICATE FAMILY HISTORY: **M**OTHER **F**ATHER **S**ISTER **B**ROTHER **G**RAND**M**OTHER **G**RAND**F**ATHER

Cancer (type)		Heart disease		HIV	
Kidney disease		Heart Attack		Ulcers	
Osteoporosis		High Blood Pressure		Gallbladder Disease	
Stroke		Blood Disease		Migraines	
Diabetes		Mental Illness		TB	
Seizures		Asthma		Thyroid Disease	
Alcoholism		Depression		Other	
Clotting Disorder		Anemia		Other	