Health History Questionnaire

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All the information that you provide in this questionnaire is strictly confidential and will become part of your medical record.

Date:

Patient Information

Patient SSN: **Patient Name:** (First/MI/Last)	**Sex:** M F	**Date of Birth:** (mm/dd/yyyy) / /
Marital Status: Single Partnered Married Separated Divorced Widowed		
Previous or Referring Doctor:		**Date of Last Exam:** (mm/yyyy): /

Personal Health History

Childhood Illness:	Measles Mumps Rubella Chicken Pox Polio Rheumatic Fever Other:

Immunizations and Dates:	Tetanus:		Pneumonia:	
	Hepatitis:		Chicken Pox:	
	Influenza:		MMR:	
	Other:			

Have you ever had a blood transfusion? No Yes Date:

List any medical problems that other doctors have diagnosed:

Diagnosis:	**Date:**

List any surgeries that you have had:

Surgery:	**Reason:**	**Date:**

List any other hospitalizations that you have had:

Hospitalization:	**Reason:**	**Date:**

List all medicines that you are currently taking (include prescribed drugs, over-the-counter drugs, vitamins, inhalers, etc.):

Name of Drug:	**Strength:**	**Frequency Taken:**	**Date Started:**

List each of the medications that you are allergic to, and the reaction that you had from taking the medications:

Name of Drug:	**Reaction You Had:**

Health Habits and Personal Safety

Exercise:	○ Sedentary (no exercise) ○ Mild exercise (climb stairs, frequent walk, golf) ○ Occasional vigorous exercise (less than 4 times per week for 30 min.) ○ Regular vigorous exercise (more than 4 times per week for 30 min.)
Diet:	Are you currently dieting?..... ○ Yes ○ No If yes, is it a physician-prescribed medical diet?..... ○ Yes ○ No Rank your salt intake..... ○ High ○ Medium ○ Low Rank your fat intake..... ○ High ○ Medium ○ Low
Caffeine:	○ Any of the following: ☐ Cola: ____ cups per day ☐ Tea: ____ cups per day ☐ Coffee: ____ cups per day ○ None
Tobacco:	Do you use tobacco?..... ○ Currently ○ Previously ○ Never If previously, when did you quit?.....

All information within this portion of the questionnaire is optional.

Sex:	Are you sexually active?.....	○ Yes ○ No
	If yes, are you trying for pregnancy?.....	○ Yes ○ No
	If not trying for pregnancy, list contraceptive or barrier method:	
	Is there any discomfort during intercourse?.....	○ Yes ○ No
	Would you like to speak with your provider about your risk of illnesses, such as HIV, AIDS, or other STDs?	○ Yes ○ No
Personal Safety:	Do you live alone?.....	○ Yes ○ No
	Do you have vision or hearing deficiencies?.....	○ Yes ○ No
	Do you have an Advanced Directive and/or Living Will?	○ Yes ○ No
	If no, would you like more information on these?.....	○ Yes ○ No
	When riding in a car, do you wear your seat belt?.....	○ Yes ○ No
Alcohol:	Do you drink alcohol?.....	○ Yes ○ No
	If yes, how many drinks per week:	
	Are you concerned about the amount you drink?.....	○ Yes ○ No
	Have you ever considered stopping?.....	○ Yes ○ No
	Are you prone to binge drinking?.....	○ Yes ○ No

Drug use
Do you currently use any illegal or non-prescribed drugs? ○ Yes ○ No
If so, please tell me about this:
Are you interested in receiving treatment for this? ○ Yes ○ No
Have you used any illegal or non-prescribed drugs in the past? ○ Yes ○ No If so, please tell me about this:

Family Health History

Family Member:	**Problem:**	**Age Diagnosed**	**Age at Death:**

		:	

Family Member:	Problem:	Age Diagnosed:	Age at Death:
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Other Problems or Medical Issues you have or would like to discuss.