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	

HEALTH MAINTENAINCE HISTORY

Immunizations dates and where it was given:	☐ T-Dap/TD	☐ Pneumonia (23)
	☐ Shingrix	☐ Prevnar 13
	☐ Influenza	
Please indicate the most recent date of each of the following:	Colonoscopy	Mammogram
	Bone Density	Pap Smear
	Eye Exam	

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

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to back page

HEALTH HABITS AND PERSONAL SAFETY						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, how many drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – packs per day	☐ Chew - # per day	☐ Pipe - #per day	☐ Cigars - #per day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you used in the past?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	Do you use Birth Control?				☐ Yes	☐ No
	If yes, what method is used:					
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?				☐ Yes	☐ No
	Do you wear seatbelts?				☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree.		
☐ Diabetes	☐ Disease of Colon	☐ Depression
☐ Headaches	☐ Bladder Problems	☐ Arthritis
☐ Congestive Heart Failure	☐ Chronic Bronchitis	☐ Gout
☐ Asthma	☐ Allergies	☐ Liver Disease
☐ High Blood Pressure	☐ Kidney Disease	☐ Anxiety
☐ Chest Pain	☐ Ear Problems	☐ Bleeding/Clotting Disorders
☐ Heart Attack	☐ Stroke	☐ Head Injury
☐ Seizures / Epilepsy	☐ Hemorrhoids	☐ Anemia
☐ High Cholesterol	☐ Prostate Problems	☐ Osteoporosis
☐ Thyroid Disease	☐ Emphysema	☐ Back Problems
☐ Chronic Cough	☐ Pneumonia	☐ Cancer: What Kind?

FAMILY HISTORY

HAS ANYONE IN YOUR FAMILY BEEN DIAGNOSED WITH THE FOLLOWING?

Heart Disease	☐ Yes	☐ No	If yes, who?
Hypertension	☐ Yes	☐ No	If yes, who?
High Cholesterol	☐ Yes	☐ No	If yes, who?
Diabetes	☐ Yes	☐ No	If yes, who?
Mental Health Issues	☐ Yes	☐ No	If yes, who?
Cancer	☐ Yes	☐ No	If yes, who?