ALBERT J. MARANO, M.D., INC.

HEALTH HISTORY QUESTIONNAIRE

All information provided is strictly confidential and will be used for Patient Records only.

Date: ☐

Address: _____ **Home Phone:** _____

_____ **Cell Phone:** _____

Patient Information

Patient Name: (First/ MI/Last) ☐ ☐ ☐	**Sex:** M O F O	**D.O.B.**(mm/dd/yyyy) ☐/☐/☐
Marital Status: O Single O Partnered O Married O Divorced O Widowed O Separated	**Social Security Number:**	
Current Occupation:	**Significant Previous Occupations:**	
Referring Doctor:	**Date of Last Exam:** (mm/yyyy) ☐/☐	
Primary Care Provider:	☐/☐	
Employer: _____		
Race: O American Indian O Asian O Black O White O Hispanic O Native Hawaiian O Other O Unknown O I do not wish to answer		
Ethnicity: O Hispanic Origin O Not of Hispanic Origin O I do not wish to answer	**Preferred Language:** _____	
IS THIS VISIT RELATED TO THE FOLLOWING: (circle one) **WORKERS COMP** **ACCIDENT** **N/A**		

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Insurance information: _____

Personal Health History

Medical Illnesses:	Illness:	Illness:
	☐ Diabetes	☐ Head Injury
	☐ Hypertension	☐ Stroke
	☐ Heart Disease	☐ Epilepsy
	☐ Asthma	☐ Bleeding Disorder
	☐ Cancer	☐ Genetic Defects
	☐ Depression	☐ Dementia
	☐ Anxiety	☐ Other
	☐ Other Psychiatric Illness	

Any Immunizations within the last 12 months:

_____

Surgery (List any surgeries you have had):

_____

_____

_____

Attach Med Sheet or list all medications and dosage that you are currently taking (include prescribed drugs, over-the-counter drugs, vitamins, and inhalers):

_____

_____

_____

_____

List any medications you are allergic to and the reaction that you experience from taking that medication:

Name of Drug:	Reaction you had:

What Pharmacy do you use (name / city / street): _____

_____

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Family Health History (Parents, Siblings, First Cousins):			
Family Member:	**Problem:**	**Age Diagnosed:**	**Age at Death:**

Health Habits

Exercise:	○ No exercise	
	○ Mild exercise (climb stairs, frequent walks, golf)	
	○ Occasional vigorous exercise (less than 3x per week for 30 min)	
	○ Regular vigorous exercise (more than 3x per week for 30 min)	
Diet:	Are you currently dieting?.....	○ Yes ○ No
	If yes, is it a physician-prescribed	
	Medical diet?.....	○ Yes ○ No
	Rate your salt intake.....	○ High ○ Medium ○ Low
	Rate your fat intake.....	○ High ○ Medium ○ Low
Caffeine: ○	Do you drink any of the following:	
	○ Soda ..... ☐ 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?	
Illicit Drugs:	Do you use illicit drugs?	○ Currently ○ Previously ○ Never

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Alcohol:	Do you drink alcohol?.....	○ Yes	○ No
	If Yes, how many days per week: ☐		
	Are you concerned about the amount you drink?...	○ Yes	○ No
	Have you ever considered stopping?.....	○ Yes	○ No