THOMPSON MEDICAL ASSOCIATES

Internal Medicine and Concierge Medicine

Name: _____ **DOB:** _____

Health & Lifestyle Questionnaire

1. **In general, how would you rate your overall health?**
   ☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. **In general, how would you rate your quality of life?**
   ☐ Excellent ☐ Good ☐ Fair ☐ Poor

3. **Any new family history?** ☐ Yes ☐ No If yes, specify: _____

4. **Any new or recent diagnosis, surgeries, or hospitalizations?**
   ☐ Yes ☐ No If yes, specify: _____

5. **Any new allergies?** ☐ Yes ☐ No If yes, specify: _____

6. Please list all names of specialists you see:

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7. **Do you exercise?** ☐ Regularly ☐ Sometimes ☐ Rarely ☐ Never

8. **Do you drink alcohol?** ☐ No ☐ Occasional ☐ Frequency _____

9. **Do you smoke, vape, or use recreational drugs?**
   ☐ No ☐ Yes ; type/amount: _____

10. **Do you wear seat belts?** ☐ Always ☐ Sometimes ☐ Never

11. **Dental visit in past 12 months?** ☐ Yes – Dentist: _____ ☐ No

12. **Dental problem in past 6 months?** ☐ Yes ☐ No

13. **Eye doctor visit in past 3 years?** ☐ Yes – Doctor: _____ ☐ No

14. **Need referral?** ☐ Dentist ☐ Eye Doctor ☐ Both ☐ None

Name & Signature: _____ **Date:** _____

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