# Apple A Day Family Medicine

## Health History Questionnaire

We ask all new patients to complete this form. All questions contained in this form are strictly confidential and will become part of your medical record.

| | |
|---|---|
| **Name** (Last, First, MI): | **Date of Birth**: |
| **Marital Status**: | |
| **Occupation**: | **Employer**: |
| **Date of last primary care visit**: | |
| **Primary Healthcare Provider**: | |

### Personal Medical History

| | |
|---|---|
| **Primary reason(s) for being seen:** | |
| **Current medical conditions:** | |
| **Past medical conditions (no longer requiring treatment):** | |

## Past Surgical History

| Procedure | Reason | Hospital & Year | City & State of Hospital |
|---|---|---|---|
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## Current Medications

**Please list all prescriptions, over the counter drugs, vitamins and supplements you take.**

| Name of Medication | Strength | How often | What year you started taking this medication |
|---|---|---|---|
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## Medication Allergies

| Medication Name | Reaction |
|---|---|
| | |
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| | |

## Non-medication Allergies

| Allergen (food, dust, mold, etc.) | Reaction |
|---|---|
| | |
| | |
| | |

## Social History

| Substance (if app.) | Amt. / day (heaviest) | Year started | Year stopped (if app.) |
|---|---|---|---|
| Tobacco | | | |
| Marijuana | | | |
| Alcohol | | | |
| Other | | | |

## Family History – Please list any illnesses that run in the family

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|---|
| Mom: |
| Dad: |
| Grandparents: |
| Siblings: |

## Review of Systems – Please briefly describe any current symptoms

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|---|
| Skin: |
| Head/Neck/Eyes: |
| Throat: |
| Lungs: |
| Chest/Heart: |
| Gynecologic: |
| Genitourinary (genitals or bladder): |
| Digestive/Gastrointestinal: |
| Back or joints: |
| Muscles and tendons: |
| Neurologic: |
| Weight (recent unintentional gain or loss): |
| Mood: |
| Energy level: |
| Other: |

**Patient Signature** **Date**