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
Reason for Visit:						
Preferred Pharmacy:						
Preferred Lab:						
Preferred Imaging Center:						
Primary Care Provider:				**Primary Care Provider Phone #:**		
Primary Care Provider Address:						

PERSONAL HEALTH HISTORY

Allergies

Name the Medication, Food, Substance, etc.	Reaction You Had

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

Name the Drug	Strength	Frequency Taken

Immunizations and dates:	☐ Pneumonia	☐ Influenza
Current Medical Problem:		

FAMILY HEALTH HISTORY

	AGE		SIGNIFICANT HEALTH PROBLEMS	AGE AT ONSET OF PROBLEM		AGE		SIGNIFICANT HEALTH PROBLEMS	AGE AT ONSET OF PROBLEM
Father					**Children**	☐ M ☐ F			
Mother						☐ M ☐ F			
Sibling	☐ M ☐ F					☐ M ☐ F			
	☐ M ☐ F					☐ M ☐ F			
	☐ M ☐ F				**Grandmother** *Maternal*				
	☐ M ☐ F				**Grandfather** *Maternal*				
	☐ M ☐ F				**Grandmother** *Paternal*				
	☐ M ☐ F				**Grandfather** *Paternal*				

Social History

How often do you drink alcohol?	
How much caffeinated coffee or other caffeinated drinks do you drink a day?	
☐ Current Smoker ☐ Never ☐ Former	
If you are a current smoker, how much do you smoke?	
Do you use tobacco in any other form? (Chew, pipe, cigar, etc.)	
Do you use E-Cigarettes or vape?	
Drug use:	

Past Surgeries

Year	Reason	Hospital

Past Medical Conditions

Year of Onset	Condition	Treatments