Health History Questionnaire

<Organization>

All the information that you provide in this questionnaire is strictly confidential and will become part of your medical record.

Date:

Patient Information

Patient SSN:

Sex: M F

Date of Birth: (mm/dd/yyyy) / /

Patient Name: (First/MI/Last)

Marital Status: Single Partnered Married Separated Divorced Widowed

Previous or Referring Doctor:

Date of Last Exam: (mm/yyyy): /

Personal Health History

Childhood Illness: Measles Mumps Rubella Chicken Pox Polio Rheumatic Fever

Other:

Immunizations and Dates:

Tetanus: Pneumonia:

Hepatitis: Chicken Pox:

Influenza: MMR:

Other:

Have you ever had a blood transfusion? No Yes Date:

List any medical problems that other doctors have diagnosed:

Diagnosis:	**Date:**

List any surgeries that you have had:

Surgery:	**Reason:**	**Date:**

List any other hospitalizations that you have had:

Hospitalization:	**Reason:**	**Date:**

List all medicines that you are currently taking (include prescribed drugs, over-the-counter drugs, vitamins, inhalers, etc.):

Name of Drug:	**Strength:**	**Frequency Taken:**	**Date Started:**

List each of the medications that you are allergic to, and the reaction that you had from taking the medications:

Name of Drug:	**Reaction You Had:**

Health Habits and Personal Safety

Exercise:	○ Sedentary (no exercise) ○ Mild exercise (climb stairs, frequent walk, golf) ○ Occasional vigorous exercise (less than 4 times per week for 30 min.) ○ Regular vigorous exercise (more than 4 times per week for 30 min.)
Diet:	Are you currently dieting?..... ○ Yes ○ No If yes, is it a physician-prescribed medical diet?..... ○ Yes ○ No Rank your salt intake..... ○ High ○ Medium ○ Low Rank your fat intake..... ○ High ○ Medium ○ Low
Caffeine:	○ Any of the following: ☐ Cola: ____ 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?.....

All information within this portion of the questionnaire is optional.

Sex:	Are you sexually active?.....	Yes	No
	If yes, are you trying for pregnancy?.....	Yes	No
	If not trying for pregnancy, list contraceptive or barrier method:		
	Is there any discomfort during intercourse?.....	Yes	No
	Would you like to speak with your provider about your risk of illnesses, such as HIV, AIDS, or other STDs?	Yes	No
Personal Safety:	Do you live alone?.....	Yes	No
	Do you have vision or hearing deficiencies?.....	Yes	No
	Do you have an Advanced Directive and/or Living Will?	Yes	No
	If no, would you like more information on these?.....	Yes	No
	When riding in a car, do you wear your seat belt?.....	Yes	No
Alcohol:	Do you drink alcohol?.....	Yes	No
	If yes, how many drinks per week:		
	Are you concerned about the amount you drink?.....	Yes	No
	Have you ever considered stopping?.....	Yes	No
	Are you prone to binge drinking?.....	Yes	No

Family Health History

Family Member:	Problem:	Age Diagnosed:	Age at Death:

Other Problems