Original Date: _____ / _____ / _____
Dates Revised: _____ / _____ / _____
_____ / _____ / _____
_____ / _____ / _____
_____ / _____ / _____

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

Previous or Referring Doctor: **Date of Last Physical Exam:**

PERSONAL HEALTH HISTORY

Childhood Illness: ❑ Measles ❑ Mumps ❑ Rubella ❑ Chickenpox ❑ Rheumatic Fever ❑ Polio

Immunizations and Dates:
❑ Tetanus ____________________
❑ Hepatitis ____________________
❑ Influenza ____________________
❑ Pneumonia ____________________
❑ Chickenpox ____________________
❑ MMR ____________________
Measles, Mumps, Rubella

List any medical problems that other doctors have diagnosed:

Surgeries:

Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital

Have you ever had a blood transfusion? .... ❑ Yes ❑ No

Please turn to next page

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

Name the Drug	Strength	Frequency Taken

Allergies to Medications:

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL HISTORY

Exercise:
- ❑ Sedentary (No exercise)
- ❑ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
- ❑ Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 minutes)
- ❑ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet:

Are you dieting? .... ❑ Yes ❑ No

If yes, are you on a physician prescribed medical diet? .... ❑ Yes ❑ No

# of meals you eat in an average day: ________

Rank *salt* intake ❑ High ❑ Medium ❑ Low   Rank ***fat*** intake ❑ High ❑ Medium ❑ Low

Caffeine: ❑ None ❑ Coffee ❑ Tea ❑ Cola   # of cups/cans per day: ________

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Alcohol:

Do you drink alcohol? .... ❑ Yes ❑ No

If yes, what kind? ______________________ How many drinks per week? _______

Are you concerned about the amount you drink? .... ❑ Yes ❑ No

Have you considered stopping? .... ❑ Yes ❑ No

Have you ever experienced blackouts? .... ❑ Yes ❑ No

Are you prone to "binge" drinking? .... ❑ Yes ❑ No

Do you drive after drinking? .... ❑ Yes ❑ No

Tobacco:

Do you use tobacco? .... ❑ Yes ❑ No

❑ Cigarettes – Packs/day_____   ❑ Chew – #/day_____   ❑ Pipe – #/day_____

❑ Cigars – #/day_____   # of years_____ or Year Quit ________

All questions contained in this questionnaire are optional and will be kept strictly confidential.