Health 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:**
Previous or referring doctor:	**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Pharmacy Name:	**Pharmacy Phone:**

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Influenza	☐ HPV (ages 9-26)

Year	**Surgeries**	**Hospital**

Year	**Other hospitalizations**	**Hospital**

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

Do any of following symptoms occur?

☐ Running Nose/Sneezing	☐ Coughing/Stuffy Nose	☐ Itchy Throat/Hives	☐ Itchy/Watery Eyes
When do you suffer from allergies?	☐ Never	☐ Seasonal	☐ All Year
Have you ever had an allergy test performed?	Yes/No	Have you ever taken allergy immunotherapy injections?	Yes/No

HEALTH HABITS AND PERSONAL SAFETY				
Alcohol	Do you drink alcohol?		☐ Yes	☐ No
	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 – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit		
Personal Safety	Do you live alone?		☐ Yes	☐ No
	Do you have frequent falls?		☐ Yes	☐ No
	Do you have vision or hearing loss?		☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?		☐ Yes	☐ No

	ALIVE (Y/N)	**FAMILY HEALTH HISTORY**
Father		
Mother		
How Many Brothers?		
How Many Sisters?		
How Many Sons?		
How Many Daughters?		

WOMEN ONLY
Age at onset of menstruation:
Date of last menstruation?
Date of last pap and rectal exam?
Date of last mammogram?

OTHER PROBLEMS		
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.		
☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

NOTE: Initial visit is to get established and place labs and screening orders. **Annual Physical/Preventive** will be scheduled on consecutive visit as needed.