TRIANGLE FAMILY MEDICINE

HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

List all medications that you take including prescription medicines, inhalers, over-the-counter medications, herbal medications, supplements, etc.

Medication Name	Dose	Frequency

List any known allergies to medications

Medication Name	Reaction

Past Medical History: Have you ever been diagnosed with any of the following? Circle yes or no.

ADHD/ADD	YES	NO		COPD	YES	NO		High Cholesterol	YES	NO
Allergies	YES	NO		Depression	YES	NO		HIV/AIDS	YES	NO
Anemia	YES	NO		Diabetes	YES	NO		Hypertension	YES	NO
Anxiety	YES	NO		Emphysema	YES	NO		Kidney Disease	YES	NO
Arthritis	YES	NO		Epilepsy	YES	NO		Migraines	YES	NO
Asthma	YES	NO		GERD	YES	NO		Osteoporosis	YES	NO
Cancer	YES	NO		Glaucoma	YES	NO		Psychiatric Condition(s)	YES	NO
Cataracts	YES	NO		Heart Disease	YES	NO		Sickle Cell Anemia	YES	NO
Congestive Heart Failure	YES	NO		Heart Murmur	YES	NO		Sleep Apnea	YES	NO
Thyroid Disease	YES	NO								

Other Medical History: _____

_____

Surgical History: List any surgeries you have ever had.

Year	Reason

Hospitalizations: List any hospitalizations.

Year	Reason

Family Medical History: List any major health problems your relatives have.

O Adopted O Family History Unknown

Relation	Age if Living	Age at Death	Major Health Problems
Mother			
Father			
Sibling(s)			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Additional Family Medical History: _____

_____

Social History:

Tobacco Use: Do you currently use any tobacco products? O Yes O No

O Smoker, Currently #Packs/day: _____

O Former Smoker, Previously Quit Date: _____ #Packs/day: _____

Alcohol: Do you drink alcoholic beverages? O Yes O No

If yes, how many drinks do you have per week/month/year? _____

Drug Use: Do you currently use any illicit drugs? O Yes O No

If yes, list: _____

Marital Status: O Single O Married O Divorced O Separated O Widowed

Occupation: _____

Health Maintenance: Please document the date of last completion and results if appropriate for the following:

Screening	Date Completed	Results
Annual Physical Exam		
Colonoscopy		
DEXA/Bone Density Scan		
Mammogram (females only)		
PAP Smear (females only)		
PSA Screen (males only)		

Vaccinations: Please give the date you had any of the following vaccines:

Influenza _____ Pneumonia _____ Tetanus _____ Chicken Pox/Varicella _____ Shingles _____

Other Treating Physicians: As your Primary Care Provider, it is our job to make sure we keep current with your other physicians and care teams. Please list any other providers below. (Ex: Eye doctor, dermatologist, OB/GYN)

Name: _____ Name: _____

Specialty: _____ Specialty: _____

Name: _____ Name: _____

Specialty: _____ Specialty: _____