HEALTH HISTORY QUESTIONNAIRE

PATIENT NAME: Date of birth:

Medical Conditions

Have you been diagnosed with any of the following medical conditions?

Diabetes	High Blood Pressure
Thyroid Condition	Heart Disease
Cancer	Asthma
Allergies	Psychiatric Conditions
HIV	High Cholesterol

For Office Use only
Chart # _____
Date _____

Check the box and give the date if you had any of the following:

Flu shot _____ Pneumonia Shot _____ Tetanus _____Chicken Pox_____

Colonoscopy_____ Bone Density_____ Last physical_____

If you are a female: Last Pap Smear_____ Mammogram_____

Please list any other past medical conditions:

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

Name the Drug	Strength	Frequency Taken
Pharmacy Name	Telephone Number	

Allergies to medications

Name the Drug	Reaction You Had

continued on reverse side

PATIENT NAME: Date of birth:

List all surgeries you have ever had	
Year	Reason

FAMILY HEALTH HISTORY				
	Age	Significant Health Problems	Conditions	Relation to you
Father			Heart Disease	
Mother			High Cholesterol	
Brother(s)			High Blood Pressure	
Sister(s)			Diabetes	
Other			Cancer	

SOCIAL HISTORY
Have you ever smoked?
Do you drink alcohol?
Have you ever used illegal drugs?
What is your marital status?
What is your occupation?

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree

Unexplained changes in weight		Fatigue		Blood in stool or dark black stool	
Coughing		Shortness of breath		Chest Pain	
Getting up at night to urinate frequently		Loss of bladder control or leaking		Recent joint or muscle pain	
Moles that concern you		Swelling or lumps in breast		Passing out/loss of consciousness	
Poor memory or memory loss		Depression		Excessive thirst	
Bowel changes/indigestion		Sinus Problems		Intolerance of heat or cold	

Signature of Patient or Patient's guardian/representative Date Reviewed by