Health History Questionnaire

Your answers on this form will help your health care provider better understand your medical concerns and conditions. if you are uncomfortable with any question, do not answer it. If you cannot remember specific details; please approximate. Add any notes you think are important. All questions contained in this questionnaire are optional and will be kept confidential.

Primary reason for todays visit_____

Other concerns_____

Allergies (List anything you are allergic to including medications, food, bee stings etc.)

Allergy	**Reaction**

Medications (List all medications including OTC, supplements, etc.)

Drug Name	**Strength**	**Frequency**

Past Medical History (check all that apply)

[ ] Anxiety Disorder
[ ] Arthritis
[ ] Asthma
[ ] Bleeding Disorder
[ ] Blood clots (or DVT)
[ ] Cancer
[ ] Coronary Artery Disease
[ ] Claustrophobic
[ ] Diabetes
[ ] Depression
[ ] Fibromyalgia
[ ] Gout
[ ] Heart Attack
[ ] HIV or AIDS
[ ] Hepatitis
[ ] High Cholesterol
[ ] High Blood Pressure
[ ] Hypothyroid
[ ] Hyperthyroid
[ ] Kidney disease or Stones
[ ] Liver disease
[ ] Osteoporosis
[ ] Reflux or Ulcers
[ ] Stroke
[ ] Tuberculosis
[ ] Other_____
_____
_____
_____
_____
_____
_____
_____

Surgical History

Surgery	**Reason**	**Year**	**Hospital**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family Health History (Check all that apply)

Mothers Name____ Living? Y N

[ ] Cancer type__________________ [ ]High Blood Pressure [ ]Heart Attack

[ ]Stroke [ ]Heart Disease [ ]Coronary Artery Disease [ ]Diabetes [ ]Genetic Disease

[ ]Other____

Fathers Name____ Living? Y N

[ ] Cancer type__________________ [ ]High Blood Pressure [ ]Heart Attack

[ ]Stroke [ ]Heart Disease [ ]Coronary Artery Disease [ ]Diabetes [ ]Genetic Disease

[ ]Other____

Siblings Name____ Living? Y N

[ ] Cancer type__________________ [ ]High Blood Pressure [ ]Heart Attack

[ ]Stroke [ ]Heart Disease [ ]Coronary Artery Disease [ ]Diabetes [ ]Genetic Disease

[ ]Other____

Siblings Name____ Living? Y N

[ ] Cancer type__________________ [ ]High Blood Pressure [ ]Heart Attack

[ ]Stroke [ ]Heart Disease [ ]Coronary Artery Disease [ ]Diabetes [ ]Genetic Disease

[ ]Other____

Siblings Name____ Living? Y N

[ ] Cancer type__________________ [ ]High Blood Pressure [ ]Heart Attack

[ ]Stroke [ ]Heart Disease [ ]Coronary Artery Disease [ ]Diabetes [ ]Genetic Disease

[ ]Other____

Maternal Grandmother Name__________________________________ Living? Y N

[ ] Cancer type__________________ [ ]High Blood Pressure [ ]Heart Attack

[ ]Stroke [ ]Heart Disease [ ]Coronary Artery Disease [ ]Diabetes [ ]Genetic Disease

[ ]Other____

Maternal Grandfather Name_____ Living? Y N

[ ] Cancer type_____ [ ]High Blood Pressure [ ]Heart Attack

[ ]Stroke [ ]Heart Disease [ ]Coronary Artery Disease [ ]Diabetes [ ]Genetic Disease

[ ]Other_____

Paternal Grandmother Name_____ Living? Y N

[ ] Cancer type_____ [ ]High Blood Pressure [ ]Heart Attack

[ ]Stroke [ ]Heart Disease [ ]Coronary Artery Disease [ ]Diabetes [ ]Genetic Disease

[ ]Other_____

Paternal Grandfather Name_____ Living? Y N

[ ] Cancer type_____ [ ]High Blood Pressure [ ]Heart Attack

[ ]Stroke [ ]Heart Disease [ ]Coronary Artery Disease [ ]Diabetes [ ]Genetic Disease

[ ]Other_____

Additional Family Members

Name_____ Relation_____ Living? Y N

[ ] Cancer type_____ [ ]High Blood Pressure [ ]Heart Attack

[ ]Stroke [ ]Heart Disease [ ]Coronary Artery Disease [ ]Diabetes [ ]Genetic Disease

[ ]Other_____

Name_____ Relation_____ Living? Y N

[ ] Cancer type_____ [ ]High Blood Pressure [ ]Heart Attack

[ ]Stroke [ ]Heart Disease [ ]Coronary Artery Disease [ ]Diabetes [ ]Genetic Disease

[ ]Other_____

Social History

Education [ ]Less than 8th grade [ ]High School [ ]2 year college [ ]4 year college

[ ]Post Graduate [ ]Technical certificate

Number of children_____

Name_____ Date of Birth_____

Name_____ Date of Birth_____

Name_____ Date of Birth_____

Name_____ Date of Birth_____

Spouse Name_____

Occupation_____ Employer_____

Caffeine use: [ ]None [ ]Moderate [ ]Heavy #Cups per day_____

Alcohol use: [ ]None [ ]Moderate [ ]Heavy #Drinks per week_____

Tobacco use: [ ]Never [ ]Quit #of years_____ Amount per day_____

Drug use: [ ]Yes [ ]No list_____