

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.):	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Previous or referring doctor:	Date of last physical exam:	

### PERSONAL HEALTH HISTORY

Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio	
Immunizations and dates:	<input type="checkbox"/> Tetanus <span style="float: right;"><input type="checkbox"/> Pneumonia</span>
	<input type="checkbox"/> Hepatitis <span style="float: right;"><input type="checkbox"/> Chickenpox</span>
	<input type="checkbox"/> Influenza <span style="float: right;"><input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i></span>

List any medical problems that other doctors have diagnosed

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**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 SAFETY**

**ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.**

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise) <input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf) <input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) <input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
<b>Diet</b>	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
<b>Caffeine</b>	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola	# of cups/cans per day?	
<b>Alcohol</b>	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Tobacco</b>	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
<b>Drugs</b>	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No