Confidential Health History Questionnaire

Patient's Name: ______________________________ **Date of Birth:** ______________________________

ALLERGIES WITH REACTION: **List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.**

1. ____
2. ____

PAST MEDICAL HISTORY

[ ] Acid Reflux Disease (or GERD)
[ ] Anxiety
[ ] Allergies
[ ] Attention Deficit (ADD/ADHD)
[ ] Asthma
[ ] Arthritis
[ ] Birth Defect
[ ] Bleeding Disorder
[ ] Blood Clots (DVT)
[ ] Cancer
[ ] Chronic Pain
[ ] Congestive Heart Failure

[ ] Depression
[ ] Gout
[ ] Heart Attack
[ ] Heart Murmur
[ ] High Cholesterol
[ ] Pacemaker
[ ] Seizures
[ ] Stroke
[ ] HIV
[ ] Major Back Problems
[ ] Diabetes
[ ] Diverticulitis

[ ] Kidney Disease
[ ] Kidney Stones
[ ] Liver Disease
[ ] Dialysis
[ ] Hypertension
[ ] Hypotension
[ ] Hyperthyroid
[ ] Hypothyroid (low thyroid)
[ ] Tuberculosis
[ ] Osteoporosis

Any other problems not listed above ____

PAST SURGICAL HISTORY:

Surgery	Reason	Year	Hospital	Surgeon

ANY OTHER HOSPITALIZATIONS?

____
____

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YOUR CARE TEAM: LIST ANY DOCTORS YOU SEE REGULARLY:

Doctor name: ______________________________ Specialty: _________________________________

Doctor name: ______________________________ Specialty: _________________________________

Doctor name: ______________________________ Specialty: _________________________________

OTHER: Please add any other information about your health that you would like your doctor to know:

____

____

____

MEDICATIONS: List all medications, including OTC, herbs, supplements, and vitamins you are taking. Please include the dose and frequency.

Medication	Dose	Frequency

FAMILY HEALTH HISTORY: (Indicate with “X” which family member has a history of which illness)

	Mother	Father	Brother(s)	Sister(s)
Asthma				
Diabetes				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Thyroid Disease				
Stroke				
Mental Illness				
Alcohol/Drug				
Cancer (type)				

PLEASE LIST BELOW ANY OTHER FAMILY HISTORY THAT YOU THINK YOUR PHYSICIAN SHOULD CONSIDER.

____

____

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SOCIAL HISTORY:

Tobacco Use

Do you smoke? ___________ If yes, how much? ___________ Packs per day __________________

How many years have you smoked? _____ If you have smoked in the past, when did you quit? _______________

Do you use other tobacco products? ______ Are you exposed to smoke? ________________________________

Alcohol/Substance Use

Do you drink alcohol? ________ How many per day ________ Per week? __________________

Have you ever used recreational or street drugs? ________ If yes, please list: ______________________________

Other Personal History

Smoke detectors at home? _______ Use seatbelts? _______ Use sunscreen? _______ Organ donor? ________

Religious Preference: ___________________

Current job: ___________________ Previous job: ________________ With whom do you live? _______________

Do you follow a special diet? __________ Your current weight? _________ Desired weight? _______________

Your weight 1 year ago: _________ What kind of exercise do you do? __________ How often? _____________

Sexual orientation: ___________ Types of birth control/protection used by you/partner __________________

Age menstrual period began: _______ Last menstrual period:____

Pregnancies:

Total number: _____ Full term: ______ Miscarriages: _____ Abortions: ______ Premature: _____ Tubal: _______

Complications: ____

Thank you for completing this form.