

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 STRICTLY CONFIDENTIAL.

Favorite Pharmacy: _____

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

ALLERGY	REACTION
1)	
2)	
3)	
4)	

MEDICATIONS: Please list all the medications you are taking. Include prescribed drugs & over the counter drugs, i.e., vitamins and inhalers.

	Drug Name	Strength	Frequency Taken
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

PAST MEDICAL HISTORY (Please check all that apply)

<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gout	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Has Pacemaker	<input type="checkbox"/> Reflux or Ulcers
<input type="checkbox"/> Bi-Polar Disorder	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Obsessive Compulsive D/O
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Post Traumatic Stress
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/>
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>
<input type="checkbox"/> Claustrophobic	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/>
<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/>
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>

HEALTH HISTORY QUESTIONNAIRE

PAST SURGICAL HISTORY:

SURGERY	REASON	YEAR
1.		
2.		
3.		
4.		
5.		

FAMILY HEALTH HISTORY

SIGNIFICANT HEALTH PROBLEMS IN MY FAMILY

RELATION	ALIVE?	AGE	ALCOHOLISM	DEPRESSION	DIABETES	HEART DISEASE	HIGH BLOOD PRESSURE	SUICIDE
MOTHER	<input type="checkbox"/> Y <input type="checkbox"/> N							
FATHER	<input type="checkbox"/> Y <input type="checkbox"/> N							
BROTHER/SISTER	<input type="checkbox"/> Y <input type="checkbox"/> N							
BROTHER/SISTER	<input type="checkbox"/> Y <input type="checkbox"/> N							
GRANDMOTHER (MATERNAL)	<input type="checkbox"/> Y <input type="checkbox"/> N							
GRANDFATHER (MATERNAL)	<input type="checkbox"/> Y <input type="checkbox"/> N							
GRANDMOTHER (PATERNAL)	<input type="checkbox"/> Y <input type="checkbox"/> N							
GRANDFATHER (PATERNAL)	<input type="checkbox"/> Y <input type="checkbox"/> N							
OTHER	<input type="checkbox"/> Y <input type="checkbox"/> N							

SOCIAL HISTORY

EDUCATION	EXERCISE	ALCOHOL	DRUGS
<input type="checkbox"/> <8TH GRADE <input type="checkbox"/> High School <input type="checkbox"/> 2 Yr College <input type="checkbox"/> 4 Yr College <input type="checkbox"/> Post Graduate	<input type="checkbox"/> No Exercise <input type="checkbox"/> Occasional Exercise <input type="checkbox"/> Moderate Exercise <input type="checkbox"/> High Level Exercise	Drink Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No How Often? <input type="checkbox"/> <3 times weekly <input type="checkbox"/> >3 times weekly # Drinks/week? _____	Do you currently use recreational or street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please check: <input type="checkbox"/> Marijuana <input type="checkbox"/> Cocaine <input type="checkbox"/> Heroin <input type="checkbox"/> Opiates <input type="checkbox"/> Methamphetamines <input type="checkbox"/> MDMA (Ecstasy/Molly) <input type="checkbox"/> Other