

Health History Questionnaire

Date of 1st visit:

Name:	Date of Birth:	Age:
Address:	City:	State: Zip:
Phone: (home)	(work)	(cell)
Circle one: Single Partnered Married Separated	Social Security Number:	
Occupation:		
Employer:		

Insurance

Insurance Company:	Phone:
Billing address:	
ID:	
Group:	
Policy holder:	Policy holder's date of birth:
Optional: The following is used for statistical purposes only.	
Number in household _____	Annual household income _____

How were you referred here? _____
 Has any other family member already been a patient here? _____

Emergency Contact _____
 Relationship _____ Phone _____
 Address _____

If under 18, name of parent _____ Phone _____

SUCCESSFUL HEALTH CARE AND PREVENTIVE MEDICINE ARE ONLY POSSIBLE WHEN THE PHYSICIAN HAS A COMPLETE UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

Are you currently receiving healthcare? Y N
 If yes, where and from whom? _____
 What was the reason? _____

If no, when and where did you last receive medical or health care?

List your health concerns that are most important to you. List in order of importance.

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

Family History

	<u>FATHER</u>	<u>MOTHER</u>	<u>BROTHERS</u>	<u>SISTERS</u>	<u>SPOUSE</u>	<u>CHILD</u>
Ages (if living)	_____	_____	_____	_____	_____	_____
Health (G=good P=poor)	_____	_____	_____	_____	_____	_____
Age at death (if deceased)	_____	_____	_____	_____	_____	_____

Check (✓) those applicable

Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hayfever/Hives	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____	_____

Medical History

When was your last immunization for:

Diphtheria	_____	Polio	_____
Pertussis	_____	Measles/Mumps/Rubella	_____
Tetanus	_____	Other	_____

If you had any of the following, please mark the date:

Chicken Pox	_____	Measles	_____
Rheumatic Fever	_____	Mumps	_____
Scarlet Fever	_____	German measles	_____

Hospitalizations and Surgeries

_____ year: _____ year: _____

 _____ year: _____ year: _____
 _____ year: _____ year: _____

Car accidents, traumas, situations of abuse

_____ year: _____
 Result: _____
 _____ year: _____
 Result: _____
 _____ year: _____
 Result: _____

Current State of Health

Allergies

Are you hypersensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmental? _____

Current Medications

Prescription Medications

1) _____

4) _____

2) _____

5) _____

3) _____

6) _____

Over the counter medications

1) _____

4) _____

2) _____

5) _____

3) _____

6) _____

Supplements and Vitamins

1) _____

4) _____

2) _____

5) _____

3) _____

6) _____

Habits

	Yes	No	In the past
Do you exercise?			
If yes, what kind and how often? _____			
How many hours of sleep do you get per night? _____			
Do you sleep well?			
Do you wake rested?			
Fall asleep easily?			
Wake in the night?			
Do you enjoy your work?			
Do you have a supportive relationship?			
Do you have a history of being abused?			
Do you use recreational drugs?			
Have you been treated for drug dependence?			
Do you use alcoholic beverages?			
Have you been treated for alcoholism?			
Do you use tobacco products?			
How many packs per day? _____			
How many years? _____			
Main interests and hobbies _____			
Do you have a religious or spiritual practice?			

How does your condition affect you?

What do you think is happening?

What do you feel needs to happen for you to get better?

What do you enjoy most in your life?

How much change are you willing to make at this time for improving your health?
MINIMAL SOME COMPLETE

Is there any information about your health you would like to add?