

HEALTH HISTORY QUESTIONNAIRE

Name:
(Last, First, M.I.)

M
 F **DOB**

Previous or Referring Doctor:

**Date of Last
Physical Exam:**

PERSONAL HEALTH HISTORY

Past Medical History: (Please indicate if (self) or (family) to any of the following):

Heart Problems:	Lung Cancer:
Diabetes:	Kidney Problems:
Vascular:	Other:

History of Cancer in Family:

Type:	Relationship:

Surgeries:

Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Name of Drug	Strength	Frequency Taken

Allergies to Medications:

Name of Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Exercise: Sedentary (No exercise) Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
 Occasional Vigorous Exercise (i.e., work or recreation less than 4x/week for 30 min.)
 Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet: Are you dieting?..... Yes No
 If yes, are you on a physician prescribed medical diet? Yes No
 # of meals you eat in an average day? _____
 Rank Salt Intake Hi Med Low Rank Fat Intake Hi Med Low

Substance Abuse: History of Substance Abuse? Yes No

Alcohol: Do you drink alcohol? Yes No

Tobacco: Do you use tobacco? Yes No
 Cigarettes - Pks/day Chew - #/day Pipe - #/day
 Cigars - #/day # of Years or Year Quit

PATIENT/GUARDIAN SIGNATURE _____

DATE _____