HEALTH HISTORY QUESTIONAIRE

Demographic Information

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

Date of Birth:_____ Place of Birth:_____

Sex:_____ Marital Status_____

If married, spouse's name:_____

Pharmacy Name and Location: _____

Current Medications: Please list or attach a list of medications

CURRENT MEDICATIONS	
Drug allergies: ❑ No ❑ Yes	
Medication	**Reaction**
1.	
2.	
3.	

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	**Dose (include strength & number of pills per day)**	**How long have you been taking this?**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Please complete back of form

Past Medical History

PAST MEDICAL HISTORY

Do you now or have you ever had:

❑ Diabetes	❑ Heart murmur	❑ Crohn's disease
❑ High blood pressure	❑ Pneumonia	❑ Colitis
❑ High cholesterol	❑ Pulmonary embolism	❑ Anemia
❑ Hypothyroidism	❑ Asthma	❑ Jaundice
❑ Goiter	❑ Emphysema	❑ Hepatitis
❑ Cancer (type)	❑ Stroke	❑ Stomach or peptic ulcer
❑ Leukemia	❑ Epilepsy (seizures)	❑ Rheumatic fever
❑ Psoriasis	❑ Cataracts	❑ Tuberculosis
❑ Angina	❑ Kidney disease	❑ HIV/AIDS
❑ Heart problems	❑ Kidney stones	

Surgeries:	Date	Procedure

Other medical conditions (please list):

WOMENS REPRODUCTIVE HISTORY:

Age of first period:

Pregnancies:

Miscarriages:

Abortions:

Have you reached menopause? Y / N At what age?

Do you have regular periods? Y / N

Family History

FAMILY HISTORY				
	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings: Brother's Sister's				
Children: Daughter's Son's				
EXTENDED FAMILY HEALTH & PSYCHIATRIC PROBLEMS PAST & PRESENT: Maternal Relatives: Paternal Relatives:				

Immunizations *(check if Yes and indicate year of last injection)*

___ Influenza	___ Pneumonia	___ MMR	___ Zostavax
___ Tetanus	___ Hepatitis A or B	___ Other	___ Shingrix

Please complete back of form

Patient Name (Last, First, M.I.):_____ Date of Birth:_____

Number of years smoking? _____ Do you chew tobacco_____ Have you thought about quitting? _____ Have you quit before?_____ How long?_____

Alcohol Use:
Do you drink alcohol? _____If, so what type(s)? _____
How many drinks do you have in 1 week? _____

Drug Use:
Any history of recreational (illegal, pain medication) drug use? _____
If so, what type(s)?_____
When? _____

Disease Exposure:
Have you been exposed or currently (circle all that apply): AIDS, HIV, Herpes, Syphillis, Tuberculosis, SARS, and/or Other(s)_____

Exercise/Nutrition:
Are you currently following a dietary lifestyle and/or regular exercise regimen? _____
How much caffeine do you consume on a daily basis?_____

Employment:
Are you currently employed? _____How many jobs are you currently working?_____
Occupation_____

List of providers other than Front Royal Family Practice who are involved in your care.

Physician/Practice Name:_____Address:_____Phone#_____

Physician/Practice Name:_____Address:_____Phone#_____

Physician/Practice Name:_____Address:_____Phone#_____

Physician/Practice Name:_____Address:_____Phone#_____

The information listed above is true to the best of my knowledge. If the information above changes I will notify Front Royal Family Practice in writing.

_____ _____

Signature Date