Health History Questionnaire

Name ___________________________________ Sex_______ Age_______ Date_________________

PAST MEDICAL/SURGICAL HISTORY

List any medical problem, major illness, or surgery; also, when you had it, or when it was first diagnosed. None

HTN; DM; MI/CAD; CVA; CHF; COPD; CRI; PUD; HEP; OA; PVD; Cancer: Colon; Breast; Prostate; Hyster; Append; Cholecyst; CABG; BTL; C/S

List any medicine you take, or should be taking None

List any medicine you are allergic to, & what happens when you take it None

FAMILY HISTORY

List any medical problems of your family, and age of diagnosis (HTN; DM; MI; cancer; colon; breast; prostate) None

SOCIAL HISTORY

CIGARETTES

Do you smoke, or ever smoked? Y N How many packs in a day? ________ How many years? _______ If quit, how long ago? ______

ALCOHOL

How many drinks do you have per day in an average week? _________

Has anyone ever had concerns about the amount you drink? Y N

SEX How old were you the first time you had sex? __________ How many partners have you had altogether? ___________________

PREGNANCIES Total __________; full term_______, premature ________, miscarriages/abortions________, living children_______

Reviewing Provider____