HEALTH HISTORY QUESTIONAIRE

Name: _____ Birthdate: _____/_____/_____

Preferred Pharmacy Name & Location: _____

Occupation / Employer: _____ Marital Status: _____

Number and age of children: _____

Names of family members who are also patients? _____

ALLERGIES *(and reaction)*

_____ _____

_____ _____

MEDICATIONS & SUPPLEMENTS *(include dose & frequency)*

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

MEDICAL HISTORY

_____

_____

SURGERIES & PROCEDURES

_____

_____

NUTRITION & EXERCISE *(briefly describe diet and exercise level)*

_____

_____

SOCIAL HISTORY

Tobacco Use
Type: _____ Amount: _____ Years: _____ Ready to Quit? YES NO

Alcohol Use:
Frequency: _____ Amount: _____ Ready to Quit? YES NO

Drug Use:
Type: _____ Ready to Quit? YES NO

Sexual:
Partners in last year: _____ *MALE* *FEMALE* *BOTH*

FAMILY HISTORY

	living?	*age at death*	*health problems*
Mother	Y N	_____	_____
Father	Y N	_____	_____
Maternal GM	Y N	_____	_____
Maternal GF	Y N	_____	_____
Paternal GM	Y N	_____	_____
Paternal GF	Y N	_____	_____
Siblings	Y N	_____	_____

PREVENTION

	month & year	*result*
Cholesterol	_____	_____
Physical Exam / Wellness Visit	_____	_____
Colonoscopy / Stool Test	_____	_____
Prostate Testing	_____	_____
Bone Density Screening	_____	_____
Mammogram	_____	_____
Pap Smear	_____	_____

	month & year
Flu Shot in last year?	_____
Tetanus/Tdap in last 10 years?	_____
Pneumonia vaccine?	_____
Shingles (Zoster) vaccine?	_____

MOOD

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	None	*several days*	*more than half*	*nearly every day*
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

Do you have a living will?	YES	NO	
Do you have a medical power of attorney?	YES	NO	Who:
Do you have or desire a do not resuscitate order (DNR)?	YES	NO	

Previous Doctor: _____ Phone Number: _____

City / State: _____ Fax Number: _____

Do you have immunization records you can supply to our clinic? YES NO