HEALTH HISTORY QUESTIONAIRE
(FOR PATIENTS ≥ 18 YEARS OLD)

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*:		☐ M ☐ F	**DOB:**	

Marital status:	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed

Previous or referring doctor:		**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Medical Illnesses (Check any medical problems that other doctors have diagnosed you with in the past)

[ ] Anxiety	[ ] Arthritis	[ ] Asthma	[ ] Blood Clots
[ ] Cancer	[ ] Heart Problems	[ ] COPD/Emphysema	[ ] Colon/Rectal Disorders
[ ] Depression	[ ] Diabetes	[ ] Easy Bleeding	[ ] Endocrine/Thyroid Disorder
[ ] Epilepsy/Seizures	[ ] Fibromyalgia	[ ] Glaucoma	[ ] Headaches
[ ] Hepatitis	[ ] HIV/AIDS	[ ] High Cholesterol	[ ] High Blood Pressure
[ ] Kidney Disease	[ ] Liver Disease	[ ] Measles	[ ] Meningitis
[ ] Myocardial Infarction	[ ] Neurological Disorders	[ ] Obstructive Sleep Apnea	[ ] Osteoporosis
[ ] Pneumonia	[ ] Rheumatic Fever	[ ] Skin Disorder	[ ] Stomach Ulcer
[ ] Stroke	[ ] TB	[ ] Varicose Veins	[ ] STD _____________
[ ] Other(s)	[ ]	[ ]	[ ]

Surgeries

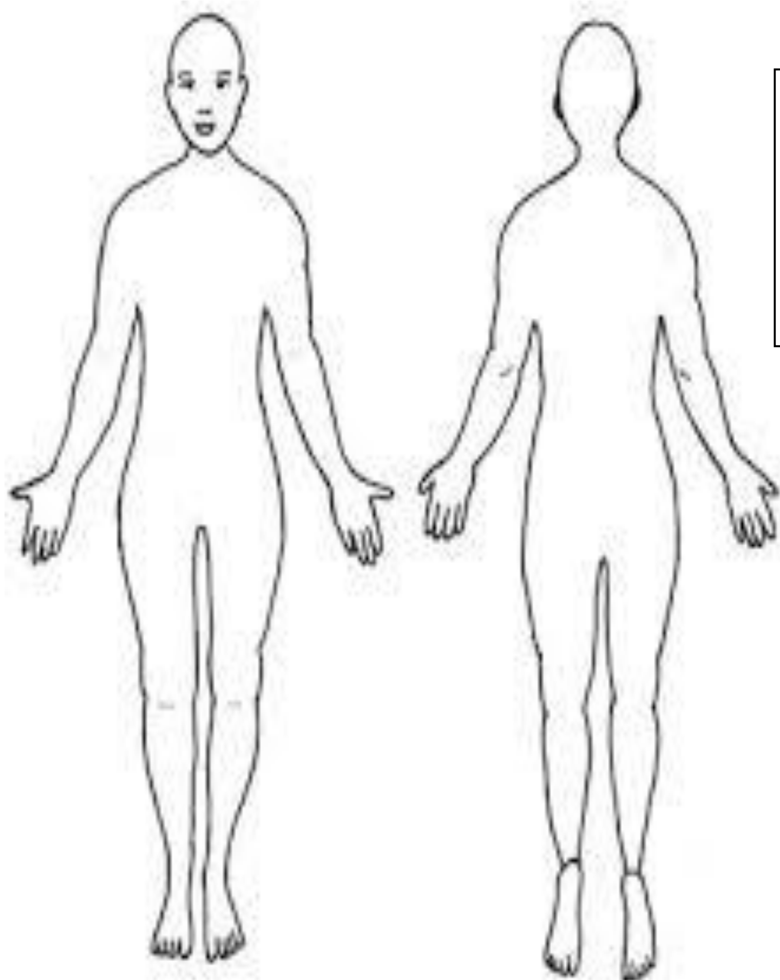
Year	Reason	Hospital

Allergies to medications ☐No Known Drug Allergies

Name the Drug or substance	Reaction You Had

	Age	Significant Health Problems		Age	Significant Health Problems
Father	☐M ☐F		**Children**	☐M ☐F	
Mother	☐M ☐F		**Siblings**	☐M ☐F	

Do you drink alcohol? □Yes □No	Would you like to talk to someone about receiving help to quit drinking? □Yes □No
Do you currently use tobacco? □Yes □No	Would you like to talk to someone about receiving help to quit smoking? □Yes □No
Do you exercise? □Yes □No If yes: How often do you exercise?___________________________	What exercises do you do? ______________________________
Are you sexually active? □Yes □No	Do you have problems with alcohol abuse? □Yes □ No
Prescription drug abuse? □Yes □No	Illegal Drug Abuse? □Yes □No
Have you ever attempted or had thoughts of suicide? □Yes □No	If yes, When? ___________________________
Were you sexually abused as a child? □Yes □No	



On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most