History Questionnaire for ALL patients 18 years of age and older.

Name: _____ Date of Birth:_____ Date: _____

❖ Please list **MEDICATION ALLERGIES**, reaction and onset if known: **(If none please indicate as none)**

_____

❖ **HOSPITALIZATION/SURGERIES** with dates if known: (You may use the back of this page if additional space is required)

_____

❖ Please list all **CURRENT MEDICATIONS**: (You may use the back of this page if additional space is required)

_____

Personal History

(Please answer the questions that are appropriate for your age and sex)

Date of last Physical_____
Last Prostate Exam_____
Last Colonoscopy_____ Was it Normal_____
Last Bone Density Test_____
Last Tetanus Vaccine_____
Last Pap Smear_____ Was it Normal_____
Last Mammogram_____ Was it Normal_____
Last EKG or Treadmill_____
Last Flu Vaccine_____

Please list any **specialist or other doctors** that you see regularly

_____

Social History

Do you drink: **Alcohol** ☐ Yes ☐ No (If Yes) Type_____amount_____per ☐ day ☐ week ☐ Month
Coffee/other caffeine drinks ☐ Yes ☐ No (If Yes) how many cups of coffee per day_____ Caffeine per day_____ Type_____
Do you: **Exercise** ☐ Yes ☐ No (If Yes) What Type_____ How Much_____ How Often_____
Do you: **Smoke** ☐ Yes ☐ No (If Yes) How many packs per day_____ How Long_____ Interested in quitting_____
Do you have any hobbies ☐ Yes ☐ No (If Yes) Please list_____
Are you: Married ☐ Divorced ☐ Single ☐ Choose not to answer ☐
Please List ALL family members seen at this office_____

Family History

	Father	Mother	Brother	Sister	**Father's Parents**		**Mother's Parents**	
					Mom	Dad	Mom	Dad
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Cancer_____Type if known	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes_____Type if known	☐	☐	☐	☐	☐	☐	☐	☐
Drug/Rx Addiction	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐
Migraine Headaches	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐
Stroke/TIA	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐	☐	☐	☐

Is there any other personal or family history that you would like to share with us?

_____

Do you have a **living will** ☐ Yes ☐ No If Yes, do we have a copy ☐ Yes ☐ No
Do you have a **durable power of attorney** ☐ Yes ☐ No If Yes, do we have a copy ☐ Yes ☐ No