Health First
Medical Group

Health History Questionnaire

Name: _____ Date of birth: _____ ❒ Male ❒ Female

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

Current complaint or illnesses

Personal Health History

Childhood illness		
Chicken pox	❒ Yes	❒ No
Measles	❒ Yes	❒ No
Mumps	❒ Yes	❒ No
Polio	❒ Yes	❒ No
Rheumatic fever	❒ Yes	❒ No
Rubella	❒ Yes	❒ No

Immunzation/Vaccine	Date
❒ Chicken pox	
❒ Hepatitis	
❒ Influenza	
❒ MMR (measles, mumps, rubella)	
❒ Pneumonia	
❒ Tetanus	
❒ Zoster (shingles)	

List any medical problems other doctors have diagnosed

Health History Questionnaire

Past Medical History

Please indicate "Yes" or "No" if you have a history of experiencing any of the following problems:

Health problem	Yes	No
Annemia/blood problems	❒	❒
Arthritis	❒	❒
Back problems	❒	❒
Bowel problems	❒	❒
Cancer	❒	❒
Depression	❒	❒
Diabetes	❒	❒
Eye problems	❒	❒
Ear/hearing problems	❒	❒
Headaches	❒	❒
Heart problems	❒	❒
High blood pressure	❒	❒

Health problem	Yes	No
High blood pressure	❒	❒
Liver disease	❒	❒
Lung/breathing problems	❒	❒
Nerve problems	❒	❒
Osteoporosis	❒	❒
Seizures	❒	❒
Skin problems	❒	❒
Stomach problems	❒	❒
Thyroid problems	❒	❒
Urine problems	❒	❒
Other (please specify): _____ _____		

Past Surgical History

Please indicate "Yes" or "No" if you have had any of following surgical procedures and the approximate date:

Surgery	Date
❒ **None**	
❒ Appendix	
❒ Back	
❒ Breast	
❒ C-section	
❒ Colon	
❒ Gallbladder	
❒ Heart	
❒ Hernia	
❒ Hysterectomy	

Surgery	Date
❒ Hip	
❒ Knee	
❒ Ovaries removed	
❒ Sinus	
❒ Stomach	
❒ Tonsils	
❒ Tubal litigation	
❒ Vasectomy	
❒ Other (please specify): _____	

Preventive Care Screening

Please indicate if you have had any of following preventive screenings and the approximate date:

Preventive test	Date
Over age 50: Colon cancer screening (colonoscopy)	_____
Women over 40: Breast cancer screening (mammogram)	_____
Women: Cervical cancer screening (Pap smear)	_____
Men over 50: Prostate cancer screening (Prostate-specific antigen [PSA] test)	_____
Bone density screening	_____

Health History Questionnaire

List Any Additional Hospitalizations

Medication

Please list **all** medications, including eye drops, over-the-counter medications and vitamins. Also include medications you are supposed to be taking but are not.

Name of medication	Dose	How often	Time of day	Not taking
Example: Metformin	1000 mg	Two times a day	Morning/evening	

Allergies to Medication

Please list all medications you have reacted to or have been told not to take. **I am allergic to:**

Name of medication	Type of adverse reaction

❒ **I hereby confirm that I am not aware of any allergy to medication.**

Food Allergies

Please list any foods you have reacted to or have been told not to eat:

Name of food	Type of adverse reaction

❒ **I am not aware of any allergy to food.**

Health History Questionnaire

Family History

Please think carefully about health problems of your family. This can be very important regarding your own diagnosis and treatment.

Health problem	Father	Mother	Siblings	Father's parents	Mother's parents	Children
Asthma	❒	❒	❒	❒	❒	❒
Bleeding disorder	❒	❒	❒	❒	❒	❒
Cancer	❒	❒	❒	❒	❒	❒
Cholesterol	❒	❒	❒	❒	❒	❒
Diabetes	❒	❒	❒	❒	❒	❒
Heart disease	❒	❒	❒	❒	❒	❒
High blood pressure	❒	❒	❒	❒	❒	❒
Kidney problems	❒	❒	❒	❒	❒	❒
Osteoporosis	❒	❒	❒	❒	❒	❒
Seizures	❒	❒	❒	❒	❒	❒
Strok	❒	❒	❒	❒	❒	❒
Thyroid problems	❒	❒	❒	❒	❒	❒
Other : _____	❒	❒	❒	❒	❒	❒

❒ **I am adopted and my family medical history is unkown.**

Social History

❒ Single ❒ Married ❒ Live-in partner ❒ Divorced ❒ Separated ❒ Widowed

Have you ever used **any** tobacco products? ❒ Yes ❒ No Did you quit? ❒ Yes ❒ No *If yes,* quit date: _____

Please check all that apply and indicate underneath the number of years and amount per day.

❒ Cigarettes ____ years _____ per day

❒ Cigars ____ years _____ per day

❒ Pipe ____ years _____ per day

❒ Chewing tobacco ____ years _____ per day

Do you drink any form of alcohol? ❒ Yes ❒ No

If yes, indicate average amount consumed per day/week/month _____ serving(s) per: ❒ day ❒ week ❒ month

Do you use illegal substances? ❒ Yes ❒ No *If yes,* which ones? _____

Do you have a Living Will (Advanced Directive) or a Durable Power of Attorney? ❒ Yes ❒ No

Do you wear car safety belts? ❒ Yes ❒ No ❒ Sometimes

Please choose your level of exercise:

❒ **Sedentary:** no exercise

❒ **Mild:** climb stairs, walk three blocks, play golf

❒ **Occasionally vigorous:** work or recreation, less than four times a week for 30 minutes

❒ **Regularly vigorous:** work or recreation, four or more times a week for 30 minutes or more