Personal and Family Health Questionnaire

Patient Name:_____ **DOB:**_____/_____/_____

1. Your Past Medical History:

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Bladder infections
- ☐ Blood clots (where?)_____
- ☐ Blood transfusion
- ☐ Bone fractures
- ☐ COPD/Lung disease
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Endometriosis
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Headaches
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Hepatitis
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Osteoporosis
- ☐ Pulmonary embolism
- ☐ Psychiatric problems
- ☐ Reflux/GERD
- ☐ Seizures
- ☐ Sickle cell disease
- ☐ Stomach ulcers
- ☐ Stroke
- ☐ Tuberculosis

☐ Cancer (type) _____ Radiation Treatment? Yes ☐ No ☐

☐ STDs (type) _____

☐ Other skin problems: _____

☐ Other_____

2. Surgeries: ☐ None **Date of last colonoscopy:** _____

(Please specify type of surgery/procedure and year)

_____

3. Medications: ☐ None

(Name/Dose)

_____ _____ _____

_____ _____ _____

_____ _____ _____

4. Allergies: ☐ None

Medications: ☐ Penicillin ☐ Sulfa Other (name): _____

Food (type): _____

Other: _____

5. Family history: ☐ Unknown

Please write which family member next to diagnosis (Parents, Maternal/Paternal Grandparents & Siblings)

- ☐ Blood clots (where?)_____
- ☐ Diabetes_____
- ☐ Genetic problems_____
- ☐ Heart disease_____
- ☐ High blood pressure_____
- ☐ Kidney problems_____
- ☐ Lung Disease/COPD _____
- ☐ Mental illness _____
- ☐ Osteoporosis _____
- ☐ Sickle cell_____
- ☐ Stroke_____
- ☐ Cancer (type)_____
- ☐ Other_____

6. Social History

YES	NO		Former	Current	
☐	☐	Tobacco	☐	☐	How many years?_____ How much do you smoke per day?_____
☐	☐	Alcohol	☐	☐	How many years?_____
☐	☐	Drugs	☐	☐	Type(s)_____
☐	☐	Caffeine			
☐	☐	Safety concerns at home/Domestic violence			
☐	☐	Vaccination for Flu			Approx. date of last injection: _____
☐	☐	Vaccination for Pneumonia			Approx. date of last injection: _____
☐	☐	Vaccination for Tetanus			Approx. date of last injection: _____
☐	☐	Have you completed an Advance Directive for Health Care, Living Will, or Physician Orders for Life Sustaining Therapy?			

Diet: ☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten-free Other_____

Exercise: ☐ None ☐ Occasional ☐ Moderate ☐ Regular

Females Only

7. Gynecological History:

In menopause? ☐ Yes ☐ No Age of menopause: _____

Date of last Bone Density Study: _____ Abnormal? ☐ Yes ☐ No

Date of last Mammogram: _____ Abnormal? ☐ Yes ☐ No

Date of last Pap Smear: _____ Abnormal? ☐ Yes ☐ No

Menstrual Flow: ☐ Light ☐ Medium ☐ Heavy ☐ None

8. Pregnancy history: ☐ None

Number of children _____

Any births within the past year? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No