Health First
FAMILY MEDICINE

MEDICAL HEALTH QUESTIONNAIRE

Name: _____ ____/____/_____ _____ **Sex:** ☐ **M** ☐ **F**
Last **First** **MI** **DOB** **AGE**

REASON FOR VISIT: _____

CURRENT MEDICATIONS (Prescription, Over-the-counter, Herbs, Vitamins)

Name of Medication	Dose	Dosing Instructions	Name of Medication	Dose	Dosing Instructions
1			5		
2			6		
3			7		
4			8		

ALLERGIES **(Please specify Allergen and Reaction below)**

☐ No Known Allergies ☐ Medication Allergies ☐ Environmental/Seasonal Allergies ☐ Latex Allergy

PERSONAL MEDICAL HISTORY (Check all that apply & Specify Type and Date)

☐ Alcoholism_____ ☐ Bleeding Disorders_____ ☐ Headaches_____ ☐ Liver Disease_____
☐ Allergies_____ ☐ Cancer_____ ☐ Hearing Loss_____ ☐ Osteoporosis_____
☐ Anemia_____ ☐ Depression_____ ☐ Heart Disease_____ ☐ Stroke_____
☐ Anxiety_____ ☐ Diabetes (type)_____ ☐ Hepatitis_____ ☐ Hyperthyroid Disease_____
☐ Asthma_____ ☐ Emphysema/COPD _____ ☐ High Blood Pressure_____ ☐ Hypothyroid Disease_____
☐ Arthritis_____ ☐ Epilepsy/Seizure Disorder_____ ☐ High Cholesterol _____ ☐ Other (specify)_____
☐ Blood Transfusion____ ☐ Glaucoma/Cataracts_____ ☐ Kidney Disease_____ ☐ NONE APPLY

HOSPITALIZATION & SURGERIES (Check all that apply. Specify and write in date)

☐ Appendix_____ ☐ Gallbladder _____ ☐ Tonsillectomy _____ ☐ NONE APPLY
☐ Adenoids _____ ☐ Heart _____ ☐ Tubal Ligation _____ ☐ Other _____
☐ Back _____ ☐ Hernia _____ ☐ Vasectomy _____
☐ Breast _____ ☐ Hysterectomy _____ ☐ C-Section _____

FAMILY HISTORY (Check all that apply. Specify type and list who had it)

☐ Asthma _____ ☐ Diabetes (specify) _____ ☐ Thyroid Disease (specify)_____
☐ Cancer (specify) _____ ☐ Heart Disease (specify) _____ ☐ High Blood Pressure _____
☐ Dementia/Alzheimer's _____ ☐ High Cholesterol _____ ☐ Other (specify)_____
☐ Depression _____ ☐ Stroke (specify)_____ ☐ NONE APPLY

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Name of Spouse, if applicable:** _____

Children (List names and Ages): _____

If applicable: ☐ Pregnant ☐ Breastfeeding

Living Situation: ☐ Live Alone ☐ With Spouse ☐ With Children/Family Members ☐ Other _____

Occupation: _____

Tobacco

Have you ever smoked? ☐ No ☐ Yes If YES, how many packs daily? _____ For how many years?_____
Do you still smoke? ☐ No ☐ Yes If NO, how many years quit? _____

Alcohol

Do you drink alcohol including beer, wine or other alcohol? ☐ No ☐ Yes ***If yes, please specify frequency:***
☐ Daily ☐ Almost Daily (4-6 times/week) ☐ 1-3 times per/week ☐ Less than one time/week

Illicit Drugs

Do you use any drugs or prescription medications not prescribed to you? (including marijuana, cocaine, amphetamines, pain or anxiety medications, etc)
☐ No ☐ Yes

If yes please specify type of drug and frequency of use: _____

HEALTH MAINTENANCE

Please provide the dates and results of the following immunizations, examinations, and tests to the best of your ability. If you have not had one of these services please indicate N/A (not applicable).

All Patients:

Last Tetanus Booster	☐ Within past 5 years	☐ Within past 10 years		☐ Unknown
Last Eye Examination	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown
Last Colonoscopy	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown
Last DEXA Bone Scan	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown

Women:

Last Pap Smear	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown
Last Mammogram	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown

Men:

Last Prostate Specific Antigen (PSA)	Date: _____	☐ Normal	☐ Abnormal	☐ Unknown

Patient/Guardian Signature:_____ **Date:**_____

The information provided on this form has been reviewed by the physician.

Physician Signature:_____ **Date:**_____