

HEALTH HISTORY QUESTIONNAIRE

Name _____

Date _____

Medical Condition/Reason for today's Visit _____

Primary Care Physician (PCP) _____

Past Medical History: Check all that apply

- | | |
|------------------------------------------------------------------|-------------------------------------------------|
| <input type="radio"/> High Blood Pressure | <input type="radio"/> Prior Stroke |
| <input type="radio"/> Diabetes | <input type="radio"/> Emphysema |
| <input type="radio"/> Prior Heart Disorder | <input type="radio"/> Cancer _____ |
| <input type="radio"/> Angina (Chest Pain) | <input type="radio"/> Any other Serious Illness |
| <input type="radio"/> Prior Heart Attack (Myocardial Infarction) | _____ |
| <input type="radio"/> Rhythm Disturbance / Arrhythmia | _____ |

Past Surgeries: _____

Current Other Medications / Put Rx name, strength, SIG, Dr. (Include OTC Meds & Vitamins) Attach LIST if more than 8 meds

_____	_____
_____	_____
_____	_____
_____	_____

Your Pharmacy Name, Address, Telephone Number

Drug Allergies: _____

Did you/Do you SMOKE
(Circle All That Apply) No Yes Used To
Type/s _____
Qty/day _____
Age Started _____
Age Quit _____

ALCOHOL INTAKE (Circle All That Apply)
Yes No Quit since _____
Type: Wine Beer Liquor _____
Freq: Daily Weekly Monthly Socially _____
Qty: _____
Last Drink _____

CAFFEINE
No Yes
Type _____
Cups/day _____

FAMILY HISTORY (Check All That Apply) Relationship & Indicate if Maternal/Paternal

- | | Onset Age | Check If Deceased | Age |
|--------------------------------------------------------------------|-----------|-----------------------|-------|
| <input type="radio"/> Unknown / Not Applicable - Adopted | | | |
| <input type="radio"/> Migraines _____ | _____ | <input type="radio"/> | _____ |
| <input type="radio"/> Strokes _____ | _____ | <input type="radio"/> | _____ |
| <input type="radio"/> Heart Attacks _____ | _____ | <input type="radio"/> | _____ |
| <input type="radio"/> Movement Disorder (Tremor, Parkinsons) _____ | _____ | <input type="radio"/> | _____ |
| <input type="radio"/> Other _____ | _____ | <input type="radio"/> | _____ |