Lake Street Family Physicians
HEALTH HISTORY QUESTIONAIRE

TODAY'S DATE:____________

PATIENT: ____DATE OF BIRTH:______________________

1. CURRENT MEDICAL HISTORY

Reason for your visit today: ____

Please list your **current medications**: **Drug Name** **Dosage**

Do you have any **drug allergies**? ☐Yes ☐No If yes, please list:

ADULT VACCINES

Are you current with the following vaccines?

Tetanus: ☐Yes ☐No Date of vaccine:___________

Pneumonia: ☐Yes ☐No Date of vaccine:___________

Influenza: ☐Yes ☐No Date of vaccine:___________

Shingles: ☐Yes ☐No Date of vaccine:___________

2. PAST MEDICAL HISTORY

Are you currently being treated or have you been treated in the past for the following conditions:

CONDITION	DESCRIBE
Yes☐ No☐ Heart disease	________________________________
Yes☐ No☐ High cholesterol	________________________________
Yes☐ No☐ High blood pressure	________________________________
Yes☐ No☐ Lung problems	________________________________
Yes☐ No☐ Asthma	________________________________
Yes☐ No☐ Gastrointestinal problems	________________________________
Yes☐ No☐ Heartburn (reflux)	________________________________
Yes☐ No☐ Urinary tract infections, recurrent	________________________________
Yes☐ No☐ Arthritis	________________________________
Yes☐ No☐ Diabetes	________________________________
Yes☐ No☐ Thyroid problems	________________________________
Yes☐ No☐ Headaches	________________________________
Yes☐ No☐ Anemia	________________________________
Yes☐ No☐ Allergies	________________________________
Yes☐ No☐ Skin problems	________________________________
Yes☐ No☐ Cancer	________________________________
Yes☐ No☐ Ear, nose, throat or sinus problems	________________________________
Yes☐ No☐ Anxiety or depression	________________________________
Yes☐ No☐ Other	________________________________

HEALTH MAINTENANCE (for women only):

Date of last PAP test: ________________ Any abnormal PAP's? ____________

Date of last Mammogram:______________ Any abnormal results? ____________

Number of pregnancies: ______ Number of deliveries: _____

PATIENT: ____DATE OF BIRTH:_______________________

3. PAST MEDICAL HISTORY:

Have you ever been hospitalized for reasons other than surgery? ☐ Yes ☐ No
If yes, reason:

Are you currently seeing other medical providers or specialists?

Physician's Name **Specialty**

Have you had any surgeries?☐Yes ☐No If yes, please list approximate date and type of surgery:

Date **Type of surgery**

4. FAMILY HISTORY

List all family members living in the patient's home:

Name	Relation	Birth Date	Health problems, if any

Please list any medical problems of the following relatives:
Father:
Mother:
Brother(s):
Sister(s):

If parent(s) is deceased, please list the age at time of death and cause of death:
Mother - Age: Cause:
Father - Age: Cause:

5. SOCIAL HISTORY

Occupation: _____________________________________☐Retired ☐Disabled ☐Student

Marital Status: ☐Married ☐Divorced ☐Single ☐Partner ☐Separated ☐Widowed

Do you have children: ☐Yes ☐No If yes, ages of children:____

Your Hobbies:____

Do you exercise? ☐Yes ☐No If yes, what type of exercise and frequency per week?

____

Do you currently use **tobacco**? ☐Yes ☐No
If yes, what type of tobacco and how much **or** # packs?: ____
Have you used tobacco in the past? ☐Yes ☐No Date you quit: _________________
Do you drink **alcohol**? ☐Yes ☐No If yes, how much per week?:_________________
How often in the last year have you had more than 4-5 drinks in a sitting? _____# times

History Reviewed by:____