Lake Street
FAMILY PHYSICIANS

HEALTH HISTORY QUESTIONAIRE

TODAY'S DATE:_____

PATIENT: _____DATE OF BIRTH:_____

1. CURRENT MEDICAL HISTORY

Reason for your visit today: _____

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

Please list your **current medications**: **Drug Name** **Dosage** **Diagnosis or reason for medication**

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	_____
Yes No Depression	_____
Yes No Other	_____

HEALTH MAINTENANCE

Date of last Colonoscopy: _____ Name of Hospital or Facility: _____

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

Date **Type of surgery**

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**

ADULT VACCINES

Are you current with the following vaccines?

Tetanus: Yes No Date of vaccine:_____ Influenza: Yes No Date of vaccine:_____

Pneumonia: Yes No Date of vaccine:_____ Shingles: Yes No Date of vaccine:_____

4. FAMILY HISTORY

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

Name	Relation	Birth Date	Health problems, if any