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

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:
Father – Age at time of death: Cause:
Mother - Age at time of death: 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
Did you ever have a drinking problem? ☐Yes ☐No _____
Do you currently use recreational drugs? ☐Yes ☐No If yes, what drugs and how often? _____
Have you used recreational drugs in the past? ☐Yes ☐No Did you ever have a drug problem? ☐Yes ☐No _____