Date:

HEALTH HISTORY QUESTIONAIRE

Name (Last, First, M.I.):	**DOB:**
Marital status:	
Previous or referreing doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Do you have advanced directions/living will? Yes No	**Who is your power of attorney?**
Past and Current Medical History	

Year	List any medical problems that doctors have diagnosed or conditions you are treated for:
Surgeries	
Year	Type:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:		
Drug Name	Strength	Frequency Taken

Allergies to Medications	
Drug Name	Reaction You Had

FAMILY HEALTH HISTORY			
Significant Health Problems			
Father	Living Deceased	Children	Living Deceased
Mother	Living Deceased	Siblings	Living Deceased
Grandfather (paternal)	Living Deceased	Grandmother (paternal)	Living Deceased
Grandfather (maternal)	Living Deceased	Grandmother (maternal)	Living Deceased
Uncles	Living Deceased	Aunts	Living Deceased

Alcohol	Do you drink alcohol?			Yes No
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you drink?			Yes No
	Have you considered stopping?			Yes No
	Have you ever experienced blackouts?			Yes No
	Are you prone to "binge" drinking?			Yes No
	Do you drive after drinking?			Yes No
Tobacco	Do you use tobacco?			Yes No
	Cigarettes - pks/day	Chew - #/day	Pipe - #/day	Cigars - #/day
	# of years	Or year quit		
Drugs	Do you currently use recreational or street drugs?			Yes No
	Have you ever given yourself street drugs with a needle?			Yes No