

HEALTH QUESTIONNAIRE

Please complete this information on the patient. This questionnaire is completely confidential and is to be used only by the doctor in order to provide you with the most comprehensive healthcare.



Patient Name

DOB

Date

Health Problems in the Past or Present

Hospital Admissions and Surgeries

Medications (If you carry a list please give to the nurse to photocopy)

Drug Allergies

Immunizations (If you have a record please give to the nurse to photocopy)

- | | | | | |
|------------------------------------|------------------------------------|----------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Tetanus | <input type="checkbox"/> TB | <input type="checkbox"/> Measles | <input type="checkbox"/> Polio | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Rubella | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diphtheria |

Childhood Illnesses

- | | | | | |
|--|----------------------------------|------------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic | <input type="checkbox"/> Mumps | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Other | | | |

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SOCIAL

Whom do you live with?

Married Single Divorced Widowed Other

Occupation

Do you exercise? Y N Wear Seatbelts Y N Smoke detectors in house? Y N

Do you/have you ever drink alcohol Y N How Much? How Often?

Do you/have you ever smoked? Y N Packs per day? Date quit for good?

Do you/have you ever used street drugs? Y N What?

FAMILY HISTORY

Relative	Age Now	Age When Deceased	Illness(es)
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

IF PATIENT IS A FEMALE

Date of last Pap smear?

Number of pregnancies?

Ever have an abnormal Pap smear? Y N

Number of live births?

If yes, how was this treated?

Number of abortions?

Date of last mammogram?

Number of miscarriages?

Any abnormal mammograms? Y N

Have you ever been abused?

What birth control are you using?

IF PATIENT IS A CHILD

Type of delivery?

Is the child in day care? Y N

Any problems with the pregnancy/delevery? Y N Any history of abuse to the child? Y N

If yes, explain

What type of discipline do you use?

Any developmental concerns?