

Patient History Questionnaire

TODAY'S DATE _____ **Pediatric**

Name _____ DOB _____

Physician _____ SSN _____

Home Phone _____ Cell Phone _____ Work Phone _____

Parent's Names _____

Reason for visit: _____

Drug Allergies: _____

Current Medications and doses: _____

Medical Problems: Anxiety Depression Diabetes
 Heart Problems High Blood Pressure Thyroid
 High Cholesterol Lung Problems
 Other (details) _____

Hospitalizations: Diagnoses/Dates: _____

Surgeries: Diagnoses/Dates: _____

Who are your other doctors that you see routinely? (please provide location & phone #) _____

Have you ever had...

- | | | | |
|-------------------------------|----------|-------------|--------------|
| 1. a colonoscopy? | Yes / No | When? _____ | Where? _____ |
| 2. a pap smear? | Yes / No | When? _____ | Where? _____ |
| 3. a mammogram? | Yes / No | When? _____ | Where? _____ |
| 4. a PSA (Prostate Screen)? | Yes / No | When? _____ | Where? _____ |
| 5. a DXA (Bone Density Test)? | Yes / No | When? _____ | Where? _____ |
| 6. a Pneumonia Shot? | Yes / No | When? _____ | Where? _____ |
| 7. a Flu Shot | Yes / No | When? _____ | Where? _____ |
| 8. a Shingles Vaccine | Yes / No | When? _____ | Where? _____ |
| 9. Tetanus Vaccine | Yes / No | When? _____ | Where? _____ |

(Please continue to the next page...)

Name _____ DOB _____

Physician _____ TODAY'S DATE _____

Do you have a Family History of:

- 1. Breast Cancer? Yes / No Who? _____
- 2. High Cholesterol? Yes / No Who? _____
- 3. Diabetes? Yes / No Who? _____
- 4. Heart Attack? Yes / No Who? _____
- 5. Other Heart Problems? Yes / No Who? _____
- 6. Stroke? Yes / No Who? _____
- 7. Colon Cancer? Yes / No Who? _____
- 8. Prostate Cancer? Yes / No Who? _____
- 8. Osteoporosis? Yes / No Who? _____
- 9. Anxiety/Depression? Yes / No Who? _____
- 10. Psychiatric/drug/alcohol problems? Yes / No Who? _____
- 11. High Blood Pressure? Yes / No Who? _____

Social History:

- 1. Are you or have you ever been a smoker? No / Yes --how often? _____
- 2. Do you drink alcohol? No / Yes --how often? _____
- 3. Do you drink caffeine? No / Yes _____
- 4. Do you exercise? No / Yes --how often? _____
- 5. What is your marital status? Single / Divorced / Widowed / Separated / Married / Engaged
- 6. Who lives with you in your home? _____

- 7. Do you have children? No / Yes If **yes**, what are their names and ages? _____

- 8. Are you employed? No / Yes-- Where? _____
If you are retired, where did you work & for how long? _____
- 9. Do you attend religious services? No / Yes-- Where? _____
- 10. What are your hobbies? _____

- 10. Do you wear seatbelts? Yes / No

In case of an emergency, who can we contact?

Name _____ Phone _____
 Name _____ Phone _____