

Patient History Questionnaire

TODAY'S DATE _____ **Adult**

Name _____ DOB _____

Physician _____ SSN _____

Home Phone _____ Cell Phone _____ Work Phone _____

Reason for visit:

Drug Allergies: _____

Current Medications and doses:

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

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? _____ |

Page 2 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? _____ |
| 9. Osteoporosis? | Yes / No | Who? _____ |
| 10. Anxiety/Depression? | Yes / No | Who? _____ |
| 11. Psychiatric/drug/alcohol problems? | Yes / No | Who? _____ |
| 12. 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 _____