CHENEY RIDGE FAMILY MEDICAL CLINIC

Health History Questionnaire

Name:_____ Date of Birth:_____ Date:_____
Occupation:_____ Religion:_____ Education:_____
Height: _____ Weight:_____ Ethnicity: _____

ALLERGIES **NONE**:_____

MEDICATIONS **NONE**:_____

What medications are you taking (including Birth Control Pills, Herbals, Vitamins, Dietary Supplements and Over the Counter?)

NAME & DOSE	NAME & DOSE

PRESENT HEALTH CONDITIONS

YES	NO	DISEASE	YES	NO	DISEASE
		Irregular Heart Beat			Prostate Problems
		Congestive Heart Failure			Gout
		Heart Attack			Arthritis
		Heart Murmur			Skin Disease, Type:
		Rheumatic Fever			Stroke
		High Cholesterol			Epilepsy/Seizures
		High Blood Pressure			Diabetes/High Blood Sugar
		Asthma			Thyroid Problems
		Emphysema/Chronic Bronchitis			Anemia/Low Blood
		Blood Clot			Bleeding Problems, Type:
		Hay fever			Blood Transfusion Problems
		Tuberculosis			Cancer, Type:
		Gallstones			Anxiety
		Liver Disease, Type:			Depression
		Kidney Stones			Glaucoma
		Kidney Disease, Type:			Colonoscopy/ Date
		Bleeding from Bowels			Results
		Ulcers in Bowels/Stomach			Other:

SURGERIES

DATE	SURGERY	DATE	SURGERY
	Cataract Surgery, Left Right		Joint Replacement of knee/hip
	Tonsils removed		Back Disc Surgery
	Neck Artery Surgery		Prostate Surgery
	Open Heart Surgery/Catheterization		Hernia Surgery
	Appendectomy		Hysterectomy
	Gallbladder Removal		Vasectomy
	Abdominal Surgery		Other:
	Broken Bone Repair		
	Joint Scope Surgery		

FAMILY HISTORY

Do you have siblings?_____ How Many?_____

YES	NO	DISEASE	RELATIONSHIP TO YOU	YES	NO	DISEASE	RELATIONSHIP TO YOU
		Heart Attack				Sickle Cell Anemia	
		High Blood Pressure				Diabetes	
		Asthma				Thyroid Problems	
		Tuberculosis				Cancer, Type:	
		Liver Disease				Cancer, Type:	
		Kidney Disease				Alcohol Abuse	
		Gout/Arthritis				Anxiety	
		Osteoporosis				Depression	
		Stroke				Glaucoma	
		Epilepsy/Seizures				Other:	
		Bleeding Problems					

OTHER HISTORY

Exercise: ☐ Never ☐ Rarely ☐ Other:_____

When was your last: Tetanus: _____, (Never) ___ / Hepatitis B: _____, (Never) ____ / Pneumovax:_____, (Never) ___

Flu shot: _____, (Never)___ / Zostavax (shingles): _____, (Never)____, / Gardasil: _____, (Never) ___

Smoking:

Have you ever smoked: ☐ Yes ☐ No How many years did you smoke? _____ When did you quit? _____

How many packs per day do you smoke now? _____ Do you use smokeless tobacco: ☐ Yes ☐ No

Caffeine Intake ☐ Yes ☐ No If yes, how much caffeine do you consume per day? _____

The following questions are very important and strictly confidential. Please answer them accurately.

Alcohol / Drugs:

Do you drink? ☐ Yes ☐ No How much? _____ How often? _____

Do you use drugs? ☐ Yes ☐ No How much? _____ How often? _____ What Kind? _____

What drugs have you used in the past? _____

FEMALE PATIENTS ONLY

Number of pregnancies_____ Number of deliveries_____ Number of elective abortions_____ Number of miscarriages _____

When was your last PAP smear? _____ Have you ever had an abnormal PAP smear? ☐ Yes ☐ No

If "Yes" when was the abnormal PAP smear? _____ What was the abnormality and treatment? _____

_____. Who is your provider for your female care? _____

When was your last Mammogram? _____ Have you ever had an abnormal Mammogram? ☐ Yes ☐ No

If "Yes" please explain: _____

What facility did you have your Mammogram done? _____

Date of last bone density: _____ What facility did you have your last bone density done? _____