Health Questionnaire

Please Print

Patient Name: _____

Occupation: _____

Date of Birth:_____**Age:**_____**Height**:_____**Weight**: _____

Ethnic Background: ___ **Caucasian** ___ **Northern European (Poland, Germany, etc.)**
___ **Southern European (Italy, Greece, etc.)** ___ **Mixed European (unknown)**
___ **other: Indicate countries of origin** _____
___ **Hispanic (Peurto Rican, Mexican, etc.)**
___ **Asian** ___ **French Canadian** ___ **Ashkenazi Jewish** ___ **African American**

Family Physician _____**Referring Physician** _____

Drug Allergies: _____

_____

Current Medical Problems: _____

_____

Surgical History: **(Inpatient and outpatient)**
Operation_____ Year_____
Operation_____ Year_____
Operation_____ Year_____

Pregnancy History:

Date	Physician/ Facility	Type of Delivery	Sex	Weight	Complications

Women's Health issues:

At what age did you start your menstrual period? _____

What was the first day of your last menstrual cycle? _____

What was the date of your last breast exam? _____ Was it normal? _____

What was the date of your last pap smear? _____ Was it normal? _____

What was the date of your last Mammogram? _____ Was it normal? _____

Are you sexually active? Y or N Birth control? Y or N Method?_____

How many pregnancies? _____ Live births _____ Miscarriages _____Abortions _____

Personal Medical History: (Please circle if you have or have had the following conditions)

- Depression
- Bleeding
- Cancer
- Diabetes
- Epilepsy
- Heart disease
- High blood pressure
- Stroke
- Other: (Please explain)

List current medications:

Date	Physician	Drug name	Dose	X per day	Other information

Family Medical History: (Please circle if a close family member has or has had the following conditions. Please tell us the relationship next to the disorder.)

- Depression
- Bleeding
- Cancer
- Diabetes
- Epilepsy
- Heart disease
- High blood pressure
- Stroke
- Other: (Please explain)

Social History:

Do you smoke? Y or N # of packs per day? _____ How long have you smoked? _____

Do you drink alcohol? Y or N # of drinks per week? _____

Do you drink Caffeine? Y or N # of cups per day? _____

Do you use illegal drugs? Y or N Type: _____

Do you exercise? Y or N Times per week? _____

Patient Signature: _____