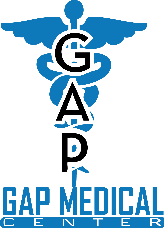
**HISTORY QUESTIONNAIRE**

Tempt: Pulse: BP: Resp: Oxy: Height: Weight: Pain: LMP: Age:

All questions contained in this questionnaire are strictly confidential

and will become a part of your medical record**.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Allergies to medications | |
| Name the Drug | Reactions You Had |
|  |  |
|  |  |
|  |  |
| □ none |  |

|  |  |  |
| --- | --- | --- |
| **List your prescribed drugs and over-the-counter- drugs, such as vitamins and inhalers** | | |
| Name the Drug | Dose | How often do you take it? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| □ none |  |  |

|  |  |  |
| --- | --- | --- |
| **Medical problems diagnosed:** | | |
| □ **High Blood Pressure** | □ **High Cholesterol** | □ **Diabetes** |
| **□ Asthma** | **□ Heart Disease** | **□ Kidney Disease** |
| **□ COPD** | **□ Strokes** | **□ Drug Addiction** |
| **Other: □** none | | |

|  |  |  |
| --- | --- | --- |
| **Surgeries** | | |
| Surgery | Year | Hospital |
|  |  |  |
|  |  |  |
|  |  |  |
| □ none |  |  |

|  |  |  |
| --- | --- | --- |
| **Other hospitalizations** | | |
| Year | Reason | Hospital |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| **Childhood illness:** | □ Measles □ Mumps □ Rubella □ Chickenpox □ Rheumatic Fever □ Polio |
| Other: □ none |

|  |  |  |
| --- | --- | --- |
| **Immunizations and dates:** | □ Tetanus | □ Pneumonia |
| □ Hepatitis | □ Chickenpox |
| □ Influenza | □ MMR ( Measles, Mumps, Rubella ) |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **FAMILY HEALTH HISTORY** | | | | | |
|  | Age | Significant health problems | | Age | Significant health problems |
| **Father** |  |  | **Children** | □ M □ F |  |
| **Mother** |  |  | □ M □ F |  |
| **Sibling** | □ M □ F |  | □ M □ F |  |
| □ M □ F |  | □ M □ F |  |
| □ M □ F |  | **Grandmother** |  |  |
| □ M □ F |  | **Grandfather** |  |  |
| □ M □ F |  | **Grandmother** |  |  |
| □ M □ F |  | **Grandfather** |  |  |

|  |  |
| --- | --- |
| What type of work do you do? |  |
| Do you consume alcohol? If yes, how much and how often? | □ No □ Yes |
| Do you consume caffeine? If yes, how much and how often? | □ No □ Yes |
| Do you use tobacco? If yes, how much and how often? | □ No □ Yes |

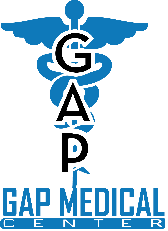
|  |
| --- |
| **Reason for visit:** |
|  |
|  |
|  |

I understand that GAP Medical Center provides urgent care services and I am responsible to have my own

primary care physician for complete preventive care services.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print) (Signature)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GAP MEDICAL CENTER**