**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: □ None** |
| □ **High Blood Pressure**  | □ **High Cholesterol**  | □ **Diabetes**  |
| **□ Asthma**  | **□ Heart Disease**  | **□ Kidney Disease**  |
| **□ COPD** | **□ Strokes**  | **□ Drug Addiction**  |
| **□ Arthritis**  | **□ Thyroid**  |  **Other:** |

|  |
| --- |
| **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**