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

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become a part of your medical record.

Have you tested positive for COVID – 19?		□ No □ Yes, When:
COVID -19 Vaccine	□ No	□ **Pfizer** □ One □ Two □ Booster □ **Moderna** □ One □ Two □ Booster □ **Johnson and Johnson** **Date Given:**

Allergies to medications: □ None

Name the Drug	Reactions You Had

List current medications prescribed and over the counter. □ None

Include inhalers, vitamins, Tylenol, Ibuprofen, Advil, Aleve…(Continue on back if you run out of space.)

Name the Drug	Dose	How often do you take it?

Medical problems diagnosed: □ None

□ **High Blood Pressure**	□ **High Cholesterol**	□ **Diabetes**
□ **Asthma**	□ **Heart Disease**	□ **Kidney Disease**
□ **COPD**	□ **Strokes**	□ **Drug Addiction**
□ **Arthritis**	□ **Thyroid**	**Other:**

Surgeries: (including Caesarean Sections and Cosmetic Procedures) □ None

Surgery	Year	Hospital

Other hospitalizations: □ None

Year	Reason	Hospital

Childhood illness:	□ Measles □ Mumps □ Rubella □ Chickenpox □ Rheumatic Fever □ Polio □ Other:

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

FAMILY HEALTH HISTORY					
	Age	Significant health problems	**Siblings**	Age	Significant health problems
Mother			□ M □ F		
Father			□ M □ F		
Maternal Grandmother			□ M □ F		
Maternal Grandfather			□ M □ F		
Paternal Grandmother			**Children** □ M □ F		
Paternal Grandfather			□ M □ F		

Females			
Last Pap Smear?	Date:	□ Normal	□ Abnormal, why?
Last Mammogram?	Date:	□ Normal	□ Abnormal, why?
Total Pregnancies:	Total Living:	Miscarriages:	Abortions:
Pregnancy complications?			

When was your last physical with blood work?	
What type of work do you do?	

Do you consume caffeine? How much and how often?	□ Coffee □ Soda □ Tea □ Energy Drinks
Do you consume alcohol? How much and how often?	□ No □ Yes
Do you use tobacco? How much and how often?	☐ Current Smoker ☐ Never Smoker ☐ Former Smoker
Do you use any type of drugs?	□ No □ Yes □ Marijuana □ Cocaine □ Heroin

Reason for your visit today:

Signature: _____ Date: _____