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.

SMOKING STATUS: ☐ Current Smoker ☐ Never Smoker ☐ Former Smoker

Allergies to medications: ☐ None

Name the Drug	Reactions You Had

List current medications prescribed and over the counter, such as vitamins and inhalers.

(Continue on back if you run out of space.) ☐ None

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)
COVID -19 Vaccine	□ No	□ **Pfizer** □ One □ Two □ **Moderna** □ One □ Two □ **Johnson and Johnson** **Date Given:**	

Have you tested positive for COVID – 19?	□ No □ Yes, When:

FAMILY HEALTH HISTORY

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

When was your last physical with blood work?	

Females			
Last Pap Smear?	Date:	□ Normal	□ Abnormal, why?
Last Mammogram?	Date:	□ Normal	□ Abnormal, why?
Total Pregnancies:			
Miscarriage or pregnancy complications?			

What type of work do you do?	
Do you consume caffeine; coffee, soda, tea, or energy drinks? If yes, how much and how often?	□ No □ Yes
Do you consume alcohol? If yes, how much and how often?	□ No □ Yes
Do you use tobacco? If yes, how much and how often?	□ No □ Yes
Do you use any type of drugs; Marijuana, Cocaine, Heroin?	□ No □ Yes

Reason for your visit today:

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: _____ Date: _____

(Signature)