

Height: Weight: Resp: Temp: BP: Oxy:

Pulse: Pain: 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 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: □ None** | | |
| Surgery | Year | Hospital |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| **Other hospitalizations: □ None** | | |
| 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 |  | **Grandmother** |  |  |
| □ M □ F |  | **Grandfather** |  |  |
| □ M □ F |  | **Grandmother** |  |  |
| □ M □ F |  | **Grandfather** |  |  |

|  |  |
| --- | --- |
| What type of work do you do? |  |
| Do you consume caffeine? 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)

**GAP MEDICAL CENTER, APOPKA**