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| ArchesLogoBlBlHEALTH HISTORY QUESTIONNAIRE |
| All questions contained in this questionnaire are strictly confidential and will become part of your medical record. |
| Name (Last, First, M.I.): |  | 🞎 M 🞎 F | DOB: |  |
| Preferred Name: |  | Preferred Pharmacy: |  |
| **If you are female, is there a possibility you are pregnant?** 🞎 Yes 🞎 No |
| **Reason for your visit today:** |
| **When did the problem begin:** |
| Reason for your visit today: |
| PERSONAL HEALTH HISTORY All questions contained in this questionnaire will be kept strictly confidential. |
|  |
| Any Childhood Illnesses: 🞎 No 🞎 Yes |
| Circle any medical problems that other doctors have diagnosed: |
| AnemiaAnxiety disorderArthritisAsthmaBlood Coagulation DisorderBlood clotsBack problemsCardiac DiseaseCancerCongestive Heart Failure | COPDCoronary Artery DiseaseDeep Vein ThrombosisDementiaDepressionDiabetes Type 1Diabetes Type 2EpilepsyReflux/GERDGout | HIV/AIDSHeadachesHeart attackHepatitisHigh Cholesterol HypertensionKidney diseaseLeg/foot ulcersLiver diseaseOsteoporosis | PneumoniaPeripheral neuropathyPeripheral vascular diseasePulmonary embolismRheumatoid arthritisSeizureStrokeThyroid diseaseUlcers/stomach |
| **Other**: |
| Surgeries |
| Year | Reason |
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|  |  |
|  |  |
|  |  |
| Other hospitalizations |
| Year | Reason |
|  |  |
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| List your prescribed and over-the-counter medications: |
| Name the Drug | Strength | Frequency Taken |
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| Allergies to medications |
| Name the Drug | Reaction You Had |
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| **Other Allergies (food, environmental, etc.)** |
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| HEALTH HABITS AND PERSONAL SAFETY |
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| All questions contained in this questionnaire will be kept strictly confidential. |
| Caffeine | 🞎 None | 🞎 Coffee | 🞎 Tea | 🞎 Cola |
| # of cups/cans per day? |
| Alcohol | Do you drink alcohol? | 🞎 | Yes | 🞎 | No |
| 🞎Beer 🞎Wine 🞎Hard Alcohol  | What best describes your drinking: social 🞎 occasional 🞎 Light 🞎 heavy 🞎  |
| Tobacco | Do you use tobacco? | 🞎 | Yes | 🞎 | No |
| 🞎 Cigarettes – pks./day | 🞎 Chew - #/day | 🞎 Vaping – #/day | 🞎 Pipe - #/day | 🞎 Cigars - #/day |
| 🞎 # of years | 🞎 Or year quit |
| Drugs | Have you ever used any illegal or street drugs? |  🞎Never Used 🞎Current User 🞎Previous User  |

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| FAMILY HEALTH HISTORY |
| Are you adopted? 🞎 yes 🞎 no |
| **Significant Health Problems** |
| **Family Member** | **List HEalth Problem:**  | **Family Member** | **List HEalth Problem:** |
| Father  | 🞎 Alive🞎Deceased |  | **Daughter** | 🞎 Alive🞎Deceased |  |
| Mother | 🞎 Alive🞎Deceased |  | **Son** | 🞎 Alive🞎Deceased |  |
| **Sister** | 🞎 Alive🞎 Deceased |  | **Grandmother***Maternal* | 🞎 Alive🞎Deceased |  |
| **Sister** | 🞎 Alive🞎 Deceased |  | **Grandmother***Paternal* | 🞎 Alive🞎Deceased |  |
| Brother | 🞎 Alive🞎 Deceased |  | **Grandfather***Maternal* | 🞎 Alive🞎Deceased |  |
| **Brother** | 🞎 Alive🞎 Deceased |  | **Grandfather***Paternal* | 🞎 Alive🞎Deceased |  |

Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_