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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: | | | | | | | | |
| Anemia  Anxiety disorder  Arthritis  Asthma  Blood Coagulation Disorder  Blood clots  Back problems  Cardiac Disease  Cancer  Congestive Heart Failure | | COPD  Coronary Artery Disease  Deep Vein Thrombosis  Dementia  Depression  Diabetes Type 1  Diabetes Type 2  Epilepsy  Reflux/GERD  Gout | | | HIV/AIDS  Headaches  Heart attack  Hepatitis  High Cholesterol  Hypertension  Kidney disease  Leg/foot ulcers  Liver disease  Osteoporosis | | Pneumonia  Peripheral neuropathy  Peripheral vascular disease  Pulmonary embolism  Rheumatoid arthritis  Seizure  Stroke  Thyroid disease  Ulcers/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 | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| 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 | | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_