FamilyFirst HEALTH

MEDICAL HISTORY QUESTIONNAIRE

Name:_____ **Date:**_____

Date of Birth:_____ **Marital Status: (circle one)** *M S D W* **Highest level of completed education:**

Sexual Orientation: (circle one) *Heterosexual Homosexual Bisexual Grade: College:*

NOTE: This is a confidential record of your medical history. As your family doctor, it is important for us to know this information so we can provide you with the best health care possible. The information contained here will not be released to anyone without your prior consent. You will be required to complete this form on a **yearly basis**.

Personal History: Check all that apply	**Medicines you are taking:**	**Family History**
Illnesses/medical problems you have had:		**Check below if any blood relatives have had any of the following:** ***Specify Relationship**
☐ ADHD/Behavioral Disorder		☐ Anemia
☐ Allergies- seasonal, pets, foods, etc.		☐ Asthma
☐ Anemia	**Medicine Allergies:**	☐ Blood Coagulation Disorder
☐ Arthritis		☐ Stroke
☐ Asthma		☐ COPD
☐ Bladder or Kidney Problems		☐ Coronary Arteriosclerosis
☐ Bleeding Disorders		☐ Dementia
☐ Blood Clots	**Seatbelts used routinely:** Yes/No	☐ Depressive Disorder
☐ Bowel Problems	**Sunscreen used routinely**: Yes/No	☐ Developmental Disorder
☐ Cancer type:	**Guns in home?** Yes/No	☐ Diabetes
☐ Chronic Pain/Fibromyalgia	**Smoke alarm in home?** Yes/No	☐ Disease of liver
☐ Congenital Anomalies/Birth Defects	**Diet**- regular, vegetarian, vegan, etc.	☐ Disorder of thyroid
☐ Depression/Mental Health Disorder	**General stress level:** low/med/high	☐ Heart Disease
☐ Diabetes	**Exercise level:** low/med/high	☐ High Cholesterol
☐ Ear or Hearing Problems	**Legally Blind or Deaf?** Yes/No	☐ High Blood Pressure
☐ HIV		☐ Immunodeficiency Disorder
☐ Head Injury/Concussion	**Occupation:**	☐ Kidney Disease
☐ Headaches	**Advance Directives:**	☐ Cancer-Type:
☐ Heart Disease	Living Will ☐ Yes ☐ No	☐ Mental Disorder
☐ Heart Problems/Murmur	Durable Power of Attorney for	☐ Migraine
☐ High Cholesterol	Health Care ☐ Yes ☐ No	☐ Obese
☐ Hypertension	If yes, please provide us with copy.	☐ Osteoporosis
☐ Liver Disease	**Females Only:**	☐ Rheumatoid arthritis
☐ Lung Disease	Age at menopause/ First Period:	☐ Seizure
☐ Musculoskeletal	Days of flow:	☐ Substance Abuse
☐ Osteoporosis	Menses monthly?	**Substance History:**
☐ Reflux/GERD/GI Ulcers	Flow: Light Moderate Heavy	Do you **Use tobacco?:** ☐ **Yes** ☐ **No**
☐ STD	Current Birth Control:	Smoke/chew (times/day) _____ Has smoked since age:_____
☐ Seizures/Epilepsy	Preform self-breast exams? yes/ no	Used to smoke but quit in _____
☐ Skin Problems	Date of Last PAP?	Do you drink **Alcohol?** ☐ **Yes** ☐ **No** If yes, how many drinks/week? _____
☐ Sleep Apnea	Abnormal PAP?	
☐ Stroke	Age at 1st pregnancy:	Do you use **drugs?** ☐ Yes ☐ No
☐ Thyroid Disease	# of Pregnancies: _____	Describe: Frequency:
☐ Vision or Eye Problems	Sexually Active? ☐ Yes ☐ No	**Caffeine intake**: occ, mod, heavy,none
Major Surgery or Hospitalizations/Year?	Are you pregnant? Yes/No Name of OB/GYN_____	**Have you been seen by any urgent care centers/ behavior health/ specialists recently?** Yes/No Why:

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