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 that 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 Health Care: YES NO	☐ Migraine
☐ High Cholesterol		☐ Obese
☐ Hypertension	If yes, please provide us with a 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):
☐ Seizures/Epilepsy	Preform self-breast exam? YES NO	Has smoked since age:
☐ Skin Problems	Date of last PAP?	Used to smoke but quit in:
☐ Sleep Apnea	Abnormal PAP?	Do you drink **Alcohol**? YES NO
☐ Stroke	Age at 1st pregnancy:	If yes, how many drinks/week:
☐ Thyroid Disease	# of pregnancies:	Do you use **drugs**? YES NO
☐ Vision or Eye Problems	Sexually active? YES NO	Describe: Frequency:
Major Surgery or Hospitalizations/Year?	Are you pregnant? YES NO	**Caffeine intake**: Occ, Mod, Heavy, None
	Name of OB/GYN:	Have you been seen by any urgent care centers/behavioral health/Specialists recently? YES NO
		Why? Date?