Name (Last, First, M.I.) _____

Date of Birth (Month, Day, Year) _____

Health History Questionnaire

If you have completed sections 1-4 since your last birthday, please proceed to section 5. **Check all that apply.**

1. Medical History

□ Anemia
□ Anxiety
□ Arthritis
□ Asthma
□ Bleeding Disorder
□ Blood Clots/DVT
□ Cancer
□ CHF/Heart Failure
□ Depression
□ Diabetes
□ Emphysema/COPD
□ GERD/Heartburn/Acid Reflux
□ Heart Disease
□ HIV/AIDS
□ Hypertension/High Blood Pressure
□ Kidney Disease
□ Liver Disease
□ Palpitations/Racing Heart
□ Seizures
□ Stroke
□ Thyroid Problems
□ Other _____

2. Surgical History

□ No Surgery
□ Anesthesia Complications
□ Appendectomy
□ Breast Surgery
□ Colonoscopy
□ Coronary Artery Bypass
□ Coronary Artery Stent
□ Eye Surgery
□ Gallbladder Surgery (Cholecystectomy)
□ Hernia Repair
Location: _____
□ Hip Replacement
□ Hysterectomy
□ Knee Replacement
□ Prostate Surgery
□ Spine Surgery
□ Organ Transplant
□ Other _____

3. Social History

Alcohol Use
□ Yes □ No □ Never
□ Wine
□ Beer
□ Liquor

Street Drug Use
□ Yes □ No □ Never
□ Marijuana
□ Methamphetamines
□ Cocaine
□ Heroin
□ Other

Tobacco Use
□ Yes □ No □ Never
Type _____
□ Current Smoker
Packs per day _____
□ Former Smoker

Sexually Active
□ Yes □ No □ Not Currently
Partners (check all that apply)
□ Female □ Male
Birth Control/Protection
□ Yes □ No
Method _____

4. Family Medical History (Check all that apply)

□ I have no family history	□ I have unknown family history

Relationship	Anemia	Anxiety	Arthritis	Asthma	Bleeding Disorder	Blood Clots/DVT	Cancer	CHF/Heart Failure	Depression	Diabetes	Emphysema/COPD	GERD/Heartburn/Acid Reflux	Heart Disease	HIV/AIDS	High Blood Pressure	Kidney Disease	Liver Disease	Palpitations/Racing Heart	Seizures	Stroke	Thyroid Problems	Other
Father																						
Mother																						
Sister																						
Brother																						
Maternal Grandmother																						
Maternal Grandfather																						
Paternal Grandmother																						
Paternal Grandfather																						
Other																						

Name (Last, First, M.I.) _____

Date of Birth (Month, Day, Year) _____

Health History Questionnaire

UR MEDICINE

5. Primary Care Network

A. Allergies to Medications/Latex – Please indicate type of reaction _____

_____

B. Medications: Please list current medications. Include herbal & over-the-counter medications, dose & how many times a day you take the medication.

Medication	Dose	How many times per day