Mountain Medical Center

PERSONAL HEALTH HISTORY QUESTIONNAIRE

Name: ________________________ Age:__________ D.O.B.____________ Date:____________

Referred by Whom?________________________ Former Physician:________________________

FAMILY HISTORY: (FOR BLOOD RELATIVES – PLEASE INDICATE WHICH RELATIVE AND WHICH SIDE OF THE FAMILY)

□ Alcoholism ________________
□ Allergies______________________
□ Anemia______________________
□ Arthritis______________________
□ Asthma______________________
□ Diabetes______________________

□ Epilepsy____________________
□ Glaucoma ____________________
□ Gout________________________
□ Heart Disease__________________
□ High BP______________________
□ Kidney Problems________________

□ Migraine__________________
□ Mental Illness ________________
□ Skin Problems________________
□ Stroke______________________
□ Suicide ______________________
□ Thyroid Dis.__________________

CANCER HISTORY………
□ Prostate_______________
□ Breast _______________
□ Ovarian_______________
□ Colon________________
□ Other________________

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____

PAST MEDICAL, ILLNESS, INJURY, AND SURGICAL HISTORY:

Year	Illness or Operation	Year	Illness or Operation

MEDICATIONS: Please list all current medications, vitamins, and supplements.

ALLERGIES: Please list all known allergies, especially to medication. Please include medication side effects.

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IMMUNIZATIONS: List approximate year of last immunizations

Tetanus______________ Pneumonia __________ Flu __________ Hepatitis_____________ MMR_________ Polio__________

HEALTH CARE MAINTENANCE:

When was your last thorough health examination?________________ Where?______________________

When was your last:

	Pap Smear____________________	Mammogram____________________
Chest X-ray__________________	Prostate Check________________	Colonoscopy / Sigmoidoscopy__________
Treadmill Test________________	PSA__________________________	Cholesterol Check______________
Blood Count__________________	Thyroid Test__________________	Liver/Kidney/Electrolytes__________

SOCIAL HISTORY

Marital History: □ Single □ Married □ Divorced □ Separated □ Widowed

Tobacco History: □ Never □ Current __ Packs/Day □ Former: quit in______ □ Prev ______ Packs/Day
□ Chewing tobacco – How long?_______

Alcohol History: □ None □ Rare □ Drinks per day ______ □ Beer □ Hard Liquor □ Wine
□ Problems – yr ______________ □ History of Detox/rehab □ History of DUI

Recreational Drug Hx: □ None □ Marijuana □ I.V. Drugs □ Other_________________

Caffeine: □ Coffee ____ cups/day □ Soda pop ____ cans/day □ Tea _____ cups/day

Current Occupation: ____

Former Occupations: ____

Exercise: (type and frequency)_ ____