Seapoint Family Healthcare

HEALTH HISTORY QUESTIONAIRE

Name: _____ **Date of Birth:** _____

What is your marital status? ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced
Are you currently… ☐ Employed ☐ Unemployed ☐ Self Employed ☐ Retired
What is/was your occupation? _____

Medical Problems:	**Surgeries:**	**Medication Allergies:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications, Vitamins, Supplements:	**Previous Health Care Providers:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list the <u>last year</u> in which you had any of the following:

_____ Physical Exam	_____ Colonoscopy/Sigmoidoscopy	_____ Hepatitis B Vaccine
_____ Pap Smear	_____ Stool Cards	_____ Pneumonia Vaccine
_____ Mammogram	_____ Cholesterol Check	_____ Tetanus Vaccine
_____ Bone Density	_____ Stress Test	_____ Flu Vaccine
_____ Vision Test	_____ Dental Exam	_____ MMR Vaccine

Do/did you smoke? ☐ No ☐ Cigarettes ☐ Smokeless Tobacco ☐ Pipe ☐ Cigars
How much do you/did you smoker per day? _____ For how may years? _____ Quit Date? _____
How much alcohol do you drink on a weekly basis? _____
Have you used illicit drugs (marijuana, heroin, cocaine, LSD, etc)? ☐ Yes ☐ No
Are you sexually active? ☐ Yes ☐ No Are your partners ☐ Male ☐ Female ☐ Both
Do you use contraception? ☐ None ☐ Condoms ☐ Pill ☐ IUD ☐ Vasectomy ☐ Diaphragm ☐ Tubal Ligation
Do you exercise? ☐ None ☐ Sometimes ☐ Regularly What type? _____

	<u>Family History</u>	**<u>Medical Problem</u>**	**<u>Age or Age of Death</u>**
Father			
Mother			
Siblings			
Children			

Patient Signature: _____ **Date:** _____