# HEALTH QUESTIONNAIRE

**Name** _____ **Date** _____

**Medical Condition/Reason for today's Visit** _____

**Primary Care Physician (PCP)** _____

**Past Medical History: Check all that apply**

- ◯ High Blood Pressure
- ◯ Diabetes
- ◯ Prior Heart Disorder
  - ◯ Angina (Chest Pain)
  - ◯ Prior Heart Attack (Myocardial Infarction)
  - ◯ Rhythm Disturbance / Arrhythmia
- ◯ Prior Stroke
- ◯ Emphysema
- ◯ Cancer _____
- ◯ Any other Serious Illness

_____

_____

**Surgeries:** _____

_____

**Current Medications / Put Rx name, strength, SIG, Dr. (Include OTC Meds & Vitamins) Attach LIST if more than 8 meds**

_____ _____

_____ _____

_____ _____

_____ _____

**Your Pharmacy Name, Address, Telephone Number**

_____

**Drug Allergies:** _____

**Did you/Do you SMOKE**

(Circle All That Apply) No Yes Used To

Type/s _____

Qty/day _____

Age Started _____

Age Quit _____

**ALCOHOL INTAKE** (Circle All That Apply)

Yes No Quit since _____

Type: Wine Beer Liquor _____

Freq: Daily Weekly Monthly Socially _____

Qty: _____

Last Drink _____

**CAFFEINE**

No Yes

Type _____

Cups/day _____

**FAMILY HISTORY (Check All That Apply)** **Relationship & Indicate if Maternal/Paternal**

| | | Onset Age | Check If Deceased | Age |
|---|---|---|---|---|
| ◯ Unknown / Not Applicable - Adopted | | | | |
| ◯ Migraines | _____ | _____ | ◯ | _____ |
| ◯ Strokes | _____ | _____ | ◯ | _____ |
| ◯ Heart Attacks | _____ | _____ | ◯ | _____ |
| ◯ Movement Disorder (Tremor, Parkinsons) | _____ | _____ | ◯ | _____ |
| ◯ Other | _____ | _____ | ◯ | _____ |