Island Family Medicine

Name *(Last, First, M.I.)*:	**DOB:**

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

REASON FOR TODAY'S VISIT – *PLEASE CIRCLE*		
ABDOMINAL PAIN	EAR PROBLEM	MEDICATION REVIEW/REFILL
ANXIETY	EXTREMITY PAIN	PHYSICAL
ASTHMA	EYE PROBLEM	RASH
BACK PAIN	F/U BIOPSY	RECTAL PROBLEM
BLOOD PRESSURE	F/U LABS	RESPIRATORY PROBLEM
BOWEL PROBLEMS	FATIGUE	SINUS PROBLEM
BREATHING PROBLEMS	FEET PAIN	SORE THROAT
CHEST PAIN	FEVER	STINGS
CONGESTION	GI PROBLEM	STOMACH PAIN
COUGH	HEADACHE / MIGRAINE	URINATION PROBLEM
DEHYDRATION	JOINT PAIN	
DEPRESSION	KIDNEY STONES	

SURGICAL HISTORY:

Procedure	Date	Comments

Medications

Please list all of the medications you are taking, including any vitamins, herbal medicines, and "over-the-counter" medications.

NAME OF MEDICATION	DOSE	FREQUENCY

PHARMACIES:		
Preferred Pharmacy	Name:	Location and Phone Number:
Secondary Pharmacy	Name:	Location and Phone Number:
Secondary Pharmacy	Name:	Location and Phone Number:

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Immunizations and dates:

☐ Hepatitis B (HepB)	☐ Pneumococcal	☐ Varicella	☐ Pneumonia	☐
☐ Rotavirus RV	☐ Inactivated Poliovirus (IPV)	☐ Hep A	☐ HPV	☐
☐ DTaP	☐ MMR *Measles, Mumps, Rubella*	☐ Td / Tdap	☐ Influenza	☐

Allergies:

Allergy	Reaction

PAST MEDICAL HISTORY: *PLEASE CIRCLE ANY YOU HAVE HAD IN THE PAST, IF NONE CIRCLE NONE.*

ADD/ADHD	GERD/reflux	LIVER DISEASE
ANXIETY DISORDER	GLAUCOMA	ORGAN TRANSPLANT
ARTHRITIS	GOUT	ORTHOPEDIC INJURY
ASTHMA	HEADACHE	OSTEOPOROSIS
BACK PAIN	HEART ARRHYTHMIA	PERIPHERAL VASCULAR DISEASE
BLEEDING DISORDER	HEART ATTACK	PULMONARY EMBOLISM
BLOOD CLOTS	HEART MURMUR	RESTLESS LEG SYNDROME
BURSITIS	HORMONE ISSUES	RHINITIS, ALLERGIC
CANCER	HYPERCHOLESTEROLEMIA	SEASONAL ALLERGIES
COPD	HYPERLIPIDEMIA	SEXUAL DYSFUNCTION
CORONARY ARTERY DISEASE	HYPERTENSION	STROKE
DEPRESSION	HYPERTHYROIDISM	ULCERS
DIABETES	JOINT PAIN	URINARY TRACT INFECTION
DIVERTICULITIS	KIDNEY DISEASE	NONE
FIBROMYALGIA	KIDNEY STONES	OTHER:

SOCIAL HISTORY

*****ALL QUESTIONS CONTAINED IN THIS SECTION ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.*****

Occupation:					
Highest Level of School:	☐ High School	☐ G.E.D.	☐ College	☐ Other:	
Marital Status:	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Exercise	☐ None	☐ Occasional	☐ Moderate	☐ Heavy	
Diet	☐ Regular	☐ Vegetarian	☐ Vegan	☐ Gluten-Free	
	☐ Specific	☐ Carbohydrate	☐ Cardiac		

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General Stress Level	☐ Low	☐ Medium	☐ High	
Smoking	Do You Smoke	☐ Yes	☐ No	
	If yes, how much per week?			
	If yes, what age did you start?			
Alcohol Intake	☐ None	☐ Occasional	☐ Moderate	☐ Heavy
Caffeine Intake	☐ None	☐ Occasional	☐ Moderate	☐ Heavy
Chewing Tobacco	☐ None	☐ 1/day	☐ 2-4/day	☐ 5+/day
Illicit Drugs:				
Guns Present in Home	☐ Yes	☐ No		
Seatbelts Used Routinely	☐ Yes	☐ No		
Sunscreen Used Routinely	☐ Yes	☐ No		
Smoke Alarm in Home	☐ Yes	☐ No		
Advance Directive	☐ Yes	☐ No		
Smoking Status	☐ Never Smoker	☐ Former Smoker	☐ Current Every Day Smoker	☐ Current Some Day Smoker
Sexually Active	☐ Yes	☐ No		

FAMILY HEALTH HISTORY

PLEASE CHECK ALL BOXES THAT APPLY:

	GRANDFATHER (MATERNAL)	GRANDMOTHER (MATERNAL)	GRANDFATHER (PATERNAL)	GRANDMOTHER (PATERNAL)	FATHER	MOTHER	BROTHER/ SISTER	BROTHER/ SISTER	BROTHER/ SISTER
ALCOHOLISM									
ARTHRITIS									
DEPRESSION									
CANCER									
DIABETES									
GENETIC DISEASE									
HEART DISEASE									
HYPERTENSION									
OSTEOPOROSIS									
STROKE									

GYN HISTORY:

Date of Last Menstrual Period:	Number of Births:	Current Sex Partner? Male or Female
If Post Menopausal, Age at Menopause:	Number of Miscarriages:	Do You Use Condoms? Yes or No
Date of Last PAP Smear:	Number of Abortions:	Other Birth Control Method Used:
Date of Last Mammogram:	C-Sections? Yes or No If yes-how many?	
Number of Pregnancies:	Sexually Active? Yes or No	

Information provided is accurate and complete. Acknowledged by: _____

Patient or Guardian (if minor) Signature