Health Questionnaire

The purpose of this questionnaire is to ensure that your electronic medical record (EMR) contains complete and up to date information so we can provide you with optimal comprehensive care. Please fill in the relevant sections to the best of your ability and give to your health care provider at your next visit. Strict confidentiality is ensured. Thank you.

Full Name:	DOB:

Past Medical History

Immunizations: (Please include dates)	Shingles? Y / N	Pneumonia? Y / N	Tetanus within past 10yrs? Y / N
To the best of your knowledge did you receive all childhood vaccines? Y / N			
Operations/Procedures (Type of Operation /Procedure):	***Reason:***		***Year:***
Other Hospitalizations (Name of Hospital):	***Reason:***		***Year***

Obstetrical History (Indicate number if any):

Total Pregnancies:	Term Deliveries (37wks or more):	Preterm Deliveries:
Miscarriages:	Pregnancy Terminations:	Living:

Family Medical History

Disease	**Relationship to you / Approximate Age of Onset**
Heart Disease:	
High Cholesterol:	
Diabetes:	
Asthma:	
Stroke:	
Dementia/Alzheimer's:	
Osteoporosis:	
Mental Health:	
Cancer (Indicate Type):	
High Blood Pressure:	
Other:	

Social History

Marital Status:	Occupation:	Spirituality:

Lifestyle	Circle What best describes your current diet:	Very Poor	Poor	Fair	Good	Excellent
Do you perform 150 minutes of moderate to vigorous activity per week? Y / N						

Tobacco	Circle your smoking status:	Ex-Smoker	Never Smoked	Smoker	Passive Smoke Contact

Cigarettes (Packs per Day):	Years Smoked:	Year Quit:

Alcohol	How many drinks per week on average?	Year Stopped:
Have you ever felt you should cut down your drinking? Y / N		
Have people annoyed you by criticizing your drinking? Y / N		
Have you ever felt bad or guilty about your drinking? Y / N		
Have you ever had a drink first thing in the morning? Y / N		

Recreational Drugs	Which recreational drugs have you used, including cannabis?
If yes, have you ever given yourself street drugs with a needle? Y / N	
How often do you usually use?	Date last used?

Sex	Sexual Orientation:	Are you sexually active? Y / N
Have you ever had sex? Y / N	If yes, what contraceptive do you use, if any?	
Do you have any problems with infertility? Y / N		

Prevention and Wellness	Have you ever been tested for Hepatitis C? Y / N Have you ever been tested for HIV? Y / N
Date of last mammogram (Recommended every 1-2yrs for women age 50+):	
Date of last PAP (Recommended every 3yrs for women age 25-70):	
Date of last stool test for colon cancer (Recommended every 2yrs for age 50+):	
Date of last cholesterol test?	

Personal Health Goals

What areas of your life would you like to make changes in?
What changes have you made/are you making so far?
What help would you like?