ALAMO Family Practice

NEW PATIENT—ADULT
HEALTH HISTORY QUESTIONNAIRE

Name _____ Date of Birth_____

Occupation_____ Married Single Divorced Widowed Partnered (circle one)

Medical Illnesses

Diagnosis	Self	Family
Acid Reflux		
Allergies		
Anemia		
Anxiety		
Arthritis		
Asthma		
Back/Neck Problem		
Bleeding Disorder		
Breast cancer		
Colon cancer		
Depression		
Diabetes		
Glaucoma		
GYN Cancer		
Hearing loss		
Heart disease		
Hepatitis		
High Blood Pressure		
High Cholesterol		
HIV/AIDS		
Kidney disease		
Liver disease		
Mental Illness		
Osteoporosis		
Physical Handicap		
Prostate cancer		
Seizures		
Sexual disease		
Skin cancer/disease		
Stroke		
Thyroid disease		
Testicular Cancer		
Tuberculosis		

Other:

Surgeries

Surgery	Date
Appendix	
Back	
Breast	
Gallbladder	
Hysterectomy	
Hernia	
Tonsils	
Tubal ligation	
Vasectomy	
Other	

OB/GYN History

Age first menses_____
Age last menses_____
pregnancies_____
Number of children___

Any abnormal pap? Y/N
If yes, list treatment

_____

Type of Birth control currently used:

Abstinence Pill
Condom IUD
Vasectomy Depo
Diaphragm None

Social History

Do you use tobacco? _____
If yes, Type/Amount_____
Do you drink alcohol? _____
If yes, How much/often_____
Have you ever used illegal drugs? _____
If yes, type/date _____
Do you exercise? _____
If yes, type/frequency _____
Spiritual Belief _____

Allergies

Please list any allergies and the reaction

_____
_____
_____
_____
_____

Preventive Services

Service	Most Recent Date
Colonoscopy	
Pap Smear/Pelvic	
Mammogram	
Bone Density	
PSA/Prostate exam	
Flu vaccine	
Pneumonia vaccine	
Shingles vaccine	
Tetanus vaccine	
Dental Exam	
Eye Exam	

Medications

Please list all prescriptions and OTC/supplements you are currently taking, along with the dose and frequency

_____
_____
_____
_____
_____
_____
_____
_____
_____