I Care Internal Medicine

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HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First, M.I.):*	**DOB:**	**Date:**	☐ M	☐ F		
Marital status:	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed

The reason(s) for today's visit:

List all medical conditions you are being treated for or have been diagnosed with:

Please list the most recent date for the following: If you have never had the test/procedure please write N/A	
Test:	Date: Please be as specific as possible
Colonoscopy	
Flu Shot	
Pap Smear- Females	
Mammogram-Females	
Bone Density	
PSA- Males	

Surgeries: (You may use the back for additional surgeries) ☐ **NONE**	
Surgery Type	Year

NAME:_____ DOB:_____ Date:_____

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers: ☐ **NONE**		
Name the Drug	Strength	Frequency Taken

Allergies to medications:	☐ **NO KNOWN ALLERGIES**
Name the Drug	Reaction You Had

	Do you use tobacco?			☐ Never	☐ Yes
	☐ Cigarettes ____ pks./day or week	☐ Chew ____ /day or week	☐ Pipe - ____#/day or week	☐ Former-Year Quit _____	
	☐ # of years	☐ Cigars #_____/Week			
	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Do you drink alcohol?			☐ Yes	☐ No
	If yes, how often? ☐Rarely ☐Weekends ☐Occasionally ☐Moderate ☐Heavy ☐Recovering Alcoholic				
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No

	SIGNIFICANT HEALTH PROBLEMS		**SIGNIFICANT HEALTH PROBLEMS**
Father		**Children**	
Mother			
Sibling			
		Grandmother *Maternal*	
		Grandfather *Maternal*	
		Grandmother *Paternal*	
		Grandfather *Paternal*	