ANDERSON MEDICAL GROUP

Health History Questionnaire

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

Patient Last Name _____ First Name _____ DOB _____

Gender: □Male □Female □Other

Marital Status: □Single □Partnered □Married □Separated □Divorced □Widowed

Living arrangements: □Alone □Family □Friends □Roommate

Previous or Referring Dr. _____ Date of last Physical Exam _____

Do you have an Advance Directive or Living Will? □Yes □No

Employer/School _____ Occupation _____

Medication List:

List your prescribed drugs, inhalers and over-the-counter drugs and vitamins.

Name of Drug	Strength	Frequency

List of Allergies and Reaction to Medications:

_____

_____

_____

List Surgery & Year:

_____

Chronic Health Problems – Check all that apply

□Allergies
□Asthma
□Anemia
□Anxiety
□Arthritis
□Blood Clots
□Cancer
□Coronary Artery Disease
□Congestive Health Failure
□COPD
□Crohns/Colitis
□Diabetes
□Gallbladder Disorder
□GERD/Acid Reflux
□Headache/Migraine
□Heart Attack
□Heart Disease
□Hepatitis
□Hyperlipidemia
□Hypertension
□Irritable Bowel Syndrome
□Kidney Disease
□OSA
□Osteoporosis
□Seizures
□Stroke
□Thyroid Disorder
□Ulcers
□Other _____

Family Medical History:

	Father	Mother	Sibling	Child	Maternal GP	Paternal GP
Alcoholism						
Asthma						
Cancer (Type)						
Diabetes						
High Blood Pressure						
Depression/Anxiety						
Heart Problems						
Stroke						
Thyroid Disorder						
Other (Describe)						

Female Patients Only:

Are you pregnant? □ Yes □ No
Number of pregnancies: _____ Miscarriages: _____ Terminated Pregnancies: ___ Live Births: ____
Date of last menstrual cycle: _____ Usual length of cycle: _____ Days of flow: _____
Usual menstrual cycle: Regular Irregular Painful/Cramps
Birth Control Method: _____
If menopausal, do you experience any symptoms? □Yes □No
Date of last PAP test: _____ Normal Abnormal
Date and Facility of last Mammogram: _____ Normal Abnormal
How often do you perform Self Breast Exams? _____

Male Patients Only:

Any urinary complaints? (hesitation in starting urine stream, decrease in force or flow, dribbling)
How many times per night do you awaken to urinate? _____
Any difficulty in getting or maintaining an erection? □Yes □No
Have you had a PSA blood test? □Yes □No Date of PSA: _____ Normal or Abnormal
Males over 50 Prostate Exam: □Yes □No Date of Prostate: _____

Health Maintenance:

	Yes	No	Date
Flu Vaccine			
Tetanus Vaccine			
Pneumonia Vaccine			
Dexa Scan			
Adults over 20 - Cholesterol			
Adults over 50 - Colonoscopy			
Have you ever had a blood transfusion?			
Would you accept blood if needed?			

Health Habits and Safety:

Do you currently use recreational or street drugs? □Yes □No
Have you ever given yourself street drugs with a needle? □Yes □No
Do you eat a healthy diet and exercise regularly? □Yes □No
If you are over the age of 65, do you experience frequent falls? □Yes □No
Are you sexually active? □Yes If yes, are you trying for a pregnancy? □No
□Yes □No
If not trying for a pregnancy, list contraceptive or barrier method used: _____
Do you fear for your safety or have a history of abuse? □Yes □No

Caffeine None □Coffee □Tea □Cola ___ # of cups or cans per day?

Alcohol Do you drink alcohol? Yes □No
If yes, what kind? _____ Amount and frequency _____
Are you concerned about the amount you drink? □Yes □No

Tobacco Do you use tobacco? □Yes □No
□ Cigarettes pks./day _____ □Chew - #/day __ □Pipe - #/day ____ □Cigars - #/day _____
□ Vaping _____ # of years. Tried to quit? □Yes □No Year quit_____

Pharmacy Name: _____ Secondary Pharmacy: _____

Signature:_____ Date: _____