HEALTH HISTORY QUESTIONNAIRE

All the information that you provide in this questionnaire is strictly confidential and will become part of your medical record.

Date: 8 (m) / 9 (d) / 2013 (y)

PATIENT INFORMATION

Name:			**Sex**:	**Date of Birth**:
christopoulos (Last)	penelope (First)	(Middle Initial)	F ☑ M ☐	7 (m) / 15 (d) / 1985 (y)

Marital Status: ☑ Single ☐ Married ☐ Common-Law ☐ Separated ☐ Divorced ☐ Widowed

Current Occupation: student

Referring Doctor: family doctor

Date of Last Physical (m/y): 1 / 2013

PERSONAL HEALTH HISTORY

Childhood Illnesses (√ all that apply)

☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken Pox ☐ Polio
☐ Rheumatic ☐ Fever ☐ Other: _____

Medical Illnesses (√ all that apply)

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☑ Asthma
☐ Bronchitis ☐ Cancer ☐ Arthritis ☐ Epilepsy
☐ Tuberculosis Other: _____

Immunization Dates (Mon/Year)

Hepatitis : _____/_____
Tetanus : may /2012
Influenza: _____/_____
Other: flu Date: _____/_____

Have you ever had a blood transfusion? ☑ **No** ☐ **Yes - Date:** ____/_____/_____

Any allergies? ☐ **No** ☑ **Yes Explain:** cat

List any surgeries that you have had in the last 5 years: no

Surgery:	**Reason:**	**Date:**

List all medicines that you are currently taking (include medicines such as prescribed drugs, over-the-counter drugs, vitamins, and inhalers):

Name of drug	Strength	Frequency Taken	Date Started
multi vitamin		everyday	
reacting			when she has allergy

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (no exercise) ☐ Mild exercise (climb stairs, frequent walk) ☐ Occasional vigorous exercise (less than 4 times per week for 30 min.) ☑ Regular vigorous exercise (more than 4 times per week for 30 min.)	
Diet	Are you currently dieting? ~~No~~ Yes If yes, is it a physician-prescribed medical diet? ~~No~~ Yes Salt intake (daily): Fat intake (daily):	
Caffeine (√ all that apply)	☑ Coffee	How many cups a day? 3 or 4 _____
	☐ Tea	How many cups a day? _____
	☐ Cola	How many cups a day? _____
Tobacco	Do you use tobacco?	☐ Yes, I do. ☑ No, I have never used it. ☐ I used to but I quit. When did you quit? ____/____ (M) (Y)
Alcohol	Do you drink alcohol?	Yes, I do. I drink about 4 or 5 _____ glasses a week. No, I have never used it. I used to but I quit. When did you quit?___/_____ (M) (Y)
Illicit Drugs	Please list any current or previous usage	no

FAMILY HEALTH HISTORY

Family Member	Medical Problem	Age Diagnosed	Age at Death
uncel	lung cancer		
father	high presser		

OTHER RELEVANT INFORMATION

headache