

# Family Healthcare Associates Health History Questionnaire

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse Name: \_\_\_\_\_

## Medications (include dose and frequency):

- |          |           |
|----------|-----------|
| 1. _____ | 7. _____  |
| 2. _____ | 8. _____  |
| 3. _____ | 9. _____  |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

## Past Medical History (please include all medical problems, hospitalizations and surgeries):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

## Social History:

Do you smoke? \_\_\_\_\_

If so, how much and for how long? \_\_\_\_\_

Are you a reformed smoker? \_\_\_\_\_ When did you quit? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_

How much and how often? \_\_\_\_\_

Do you exercise? \_\_\_\_\_

How often and what type? \_\_\_\_\_

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## Family History (include all major medical illnesses or conditions):

Father \_\_\_\_\_

Mother \_\_\_\_\_

Brothers \_\_\_\_\_

Sisters \_\_\_\_\_

Children \_\_\_\_\_