

FAMILY MEDICINE HEALTH QUESTIONNAIRE

Please answer all questions as thoroughly as possible.

Name: _____ Birth Date: _____ Date: _____

Last doctor seen, when, and why? _____

List all your current medications, including non-prescription drugs: _____

Allergies: _____

Hospitalizations/Surgeries/Injuries:

Reason	Date	Reason	Date

Personal Family History:

Family Member	Alcoholism	Anemia	Arthritis	Asthma/Lung Disease	Cancer (type/location)	Diabetes	Epilepsy/Seizures	Heart Attack	Coronary Artery Disease	High cholesterol	High blood pressure	Glaucoma	Mental illness (type)	Migraines	Osteoporosis	Stroke	Tuberculosis	Ulcers	Hepatitis/Liver Disease	Cause of Death?	Age at Death
Self																					
Spouse																					
Mother																					
Father																					
Brother																					
Sister																					
Children																					
Grandparent																					

Social History:

Marital Status: _____ Children? Yes No Ages: _____

Who lives in household? _____

Education (highest grade or degree obtained): _____

Current job/position: _____

Recent past employments: _____

Religious preference: _____

Do you wear a seat belt? Always Never Sometimes

Do you smoke? Yes _____ packs/day No

Do you drink alcoholic beverages? Yes _____ drinks per _____ No

Have you ever used drugs such as marijuana, cocaine, etc. ? Yes No

Sexual preference: Male Female

Hobbies/Exercise: _____