Valley Health
PHYSICIAN ALLIANCE

HEALTH HISTORY QUESTIONNAIRE

Name: *(Last, First, M.I.)*_____ □M □F DOB:_____

Date:_____ Marital Status: □ Single □ Partner □ Married □ Separated □ Divorced □ Widowed

Number of children:____ How many live with you?____ Occupation is/was?_____ Disabled □ Yes □ No

Previous or referring doctor:_____ Date of last physician exam:_____

Reason for today's visit:_____

Personal Health History

Do you have an Advanced Directives? *(Advance Directives refer to a person's instructions about future medical care, in the event the person becomes unable to speak for himself/herself. A Living Will is an example of an Advance Directive)* . . . . . ☐ Yes ☐ No

Are you up to date on your vaccinations? ☐ Y ☐ N

Pneumonia ☐ Y ☐ N, Shingles ☐ Y ☐ N, Tetanus ☐ Y ☐ N, D-TAP ☐ Y ☐ N, Influenza ☐ Y ☐ N ☐ Decline

Tests/Screenings and Dates: ☐ Mammogram_____ Result: ☐ Normal ☐ Abnormal, ☐ PAP_____ Result: ☐ Normal ☐ Abnormal,
☐PSA_____ Result: ☐ Normal ☐ Abnormal, ☐Colonoscopy_____ Result: ☐ Normal ☐ Abnormal
☐Diabetic Eye Exam_____ Result: ☐ Normal ☐ Abnormal, Diabetic Foot Exam_____ Result: ☐ Normal ☐ Abnormal,
☐Dexa Scan_____ Result: ☐ Normal ☐ Abnormal, ☐ Chest X-Ray_____ Result: ☐ Normal ☐ Abnormal

Surgeries/Hospitalization

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

☐ I have had no surgeries ☐ I have never been hospitalized
Have you ever had a blood transfusion? ☐ Y ☐ N

Please list other physicians you have seen in the last 12 months, and for what reason.

Physician_____ Reason_____

Physician_____ Reason_____

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YOUR MEDICAL HISTORY

Asthma	☐ Y ☐ N	Gastrointestinal Disease	☐ Y ☐ N	Thyroid Disease	☐ Y ☐ N
Behavioral Disorders	☐ Y ☐ N	Heart Attack	☐ Y ☐ N	Urological Disease	☐ Y ☐ N
Cancer	☐ Y ☐ N	High Blood Pressure	☐ Y ☐ N	Arrythmia	☐ Y ☐ N
		High Cholesterol	☐ Y ☐ N	Depression	☐ Y ☐ N
Type:_____		Musculoskeletal Disease	☐ Y ☐ N	Emphysema/COPD	☐ Y ☐ N
Type:_____		Neurological Disorders	☐ Y ☐ N	Seizures	☐ Y ☐ N
Cardiovascular Disease	☐ Y ☐ N	Pulmonary Disease	☐ Y ☐ N	Stroke	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Skin Disease	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N
Endocrine Disease	☐ Y ☐ N	STD	☐ Y ☐ N	Any other conditions	☐ Y ☐ N
Kidney Disease	☐ Y ☐ N	Hepatitis	☐ Y ☐ N	or symptoms	

List any other past medical problems: _____

_____

List your prescribed medications and any over the counter medications and any vitamins or supplements.

_____ Dose/Frequency_____ _____ Dose/Frequency_____

_____ Dose/Frequency_____ _____ Dose/Frequency_____

_____ Dose/Frequency_____ _____ Dose/Frequency_____

_____ Dose/Frequency_____ _____ Dose/Frequency_____

☐ List additional drugs on back of questionnaire. ☐ I take no medications, vitamins, supplements, or any other over the counter medications.

Allergies

Name_____ Name_____

Name_____ Name_____

☐ I have no drug allergies.

FAMILY MEDICAL HISTORY

Please indicate if YOUR FAMILY has a history of the following: (***ONLY*** *include parents, grandparents, siblings and children*)
F- Father, **M**- Mother, **B** -Brother, **S**- Sister, **MGM**- Maternal grandmother, **MGF**- Maternal grandfather,
PGM- paternal grandmother **PGF**- Paternal grandfather

☐ I am adopted and do not know biological family history. ☐ Family history unknown.

___Alcohol Abuse	___Diabetes	___Osteoporosis	
___Arthritis	___Heart Disease	___Other Cancer	☐Mother, Grandmother, Sister developed heart disease before the age of 65.
___Asthma	___High Blood Pressure	___Seizures/Convulsions	
___Bleeding Disease	___High Cholesterol	___Stoke/CVA of the Brain	
___Breast Cancer	___Kidney Disease	___Thyroid Problems	☐Father, Grandfather or Brother developed heart disease before the age of 65.
___Colon Cancer	___Lung/Respiratory Disease		
___Depression	___Mental Illness	☐NONE OF THE ABOVE	☐Other:_____

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SOCIAL HISTORY

Exercise Do you exercise? ☐ Y ☐ N If yes, how many times per week? _____

Caffeine Do you drink caffeine: ☐ Y ☐ N If yes, ☐ Coffee ☐ Tea ☐ Soda Amount per day? _____

Alcohol Do you drink alcohol? ☐ Y ☐ N If yes, how many drinks per week? _____

Tobacco Do you use tobacco of any kind? ☐ Y ☐ N If yes, how many times per day? _____

What type?_____

Drugs Do you currently use recreational or street drugs? ☐ Y ☐ N If yes, how many times a day? _____

What type? _____

These questions are for WOMEN ONLY

Do you see a Gynecologist? ☐ Y ☐ N If yes, name of provider? _____

Age at onset of menstruation:_____ Date of last menstruation:_____

Number of pregnancies: _____ Number of live births:_____ Number of Miscarriage/Abortion:_____

These questions are for MEN ONLY

Do you usually get up to urinate during the night? ☐ Y ☐ N If yes, how many times? _____

Date of last prostate and rectal exam _____

Sexual History

Are you sexually active? ☐ Y ☐ N With : ☐ Men ☐ Women ☐ Both

Do you use any form of protection? ☐ Y ☐ N If yes, which type? _____

I certify the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:_____ Date:_____

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Pharmacy Information

Local Pharmacy

Patient Name:_____ DOB:_____

Pharmacy Name: _____

Pharmacy Phone Number: _____ Fax Number: _____

Pharmacy Address: _____

_____

Major Cross Streets: _____

Mail Order Pharmacy

Do you use a mail order pharmacy? □ Y □ N

If yes, please complete:

Mail Order Pharmacy Name: _____

Phone Number: _____ Fax Number: _____

Address: _____