FAMILY PHYSICIANS OF ENCINITAS

HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First)* ☐ M ☐ F	**DOB:**____ Today's date_____
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Current or recent employment_____	**Names of Children**_____ _____ _____ _____

PERSONAL HEALTH HISTORY

Childhood illnesses: ☐ mumps ☐ rubella ☐ chickenpox ☐ pneumonia

List any <u>medical problems</u> that other doctors have diagnosed (e.g. asthma, diabetes, migraines, cancer) & do they still exist?

<u>Surgeries</u>

Year	Reason	Surgeon

Other hospitalizations

Year	Reason	Hospital

	AGE	<u>FAMILY HISTORY OF DISEASES?</u>
Father		
Mother		
Other family members with health problems		

Name_____

List your prescribed drugs and inhalers

Name the Drug (Trade or generic name)	Strength (?mgs, %, liquid vs. tablets)	Frequency Taken (e.g. 2X/day, as needed, every 8 hours)

Allergies to medications or Food or Bees or Latex

Name the Drug or Food or other	Reaction You Had

HEALTH HABITS AND SOCIAL HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise

- ☐ Sedentary (No exercise)
- ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
- ☐ Vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
- ☐ Are you an elite or professional athlete?

Alcohol

Do you drink alcohol? Yes ☐

If so do you drink socially ? ◯ Daily or alone? ◯ Excessively? ◯

Are you concerned about the amount your or your family members drinking?_____

Living Will?

Would like information on an Advanced Directive or Living Will?

Tobacco

Do you use tobacco? Yes

☐ Cigarettes – __pks./day | ☐ Chew - __/day | ☐ Cigars - __/day

☐ # of years | ☐ Or year quit

Drugs

Do you currently use recreational or street drugs? Type_____

Have you ever given yourself street drugs with a needle? Type_____

Sex

Do you have a question about a sexually sensitive topic?_____ Do you desire an HIV test? Yes ☐

Are you trying for a pregnancy? Yes ☐

If not trying for a pregnancy list contraceptive or barrier method used (e.g. the pill)
_____

Are you desiring any tests for sexually transmitted disease Yes ☐ No

Name_____

INFECTION HISTORY

Have you had a blood transfusion and if so when?

Describe if you have had pneumonia?_____		
Do you have hepatitis C?_____		
Have you had tuberculosis or a prior time with a positive TB skin test?_____		
Are you known to be immunocompromised and why?_____		
Do you have herpes or the HPV virus?_____		
Immunizations and dates:	☐ date of last Tetanus shot____	☐ have you had the Pneumonia shot?(yr?)_____
	☐ have you had the Hep A or B vaccines(describe,dates)_____	☐ year you had chicken pox or the vaccine?_____
	☐ have you had the Meningitis vaccine? (date)_____	☐ have you had the shingles vaccine? (for the elderly?)_____
XXXXXXXXXXXXXXXXX		XXXXXXXXXXXXXXXXXXXXXXXXX
Do you see any **Specialists** regularly?		Name_____ Specialty_____ Name_____ Specialty_____ Name_____ Specialty_____