

VALLEY-WIDE HEALTH SYSTEMS, INC.

HEALTH HISTORY QUESTIONNAIRE

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

Name(print):	<input type="checkbox"/> M	<input type="checkbox"/> F	DOB:
Marital status:	<input type="checkbox"/> Single	<input type="checkbox"/> Partnered	<input type="checkbox"/> Married
	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
Occupation:	Date of last physical exam:		
Why are we seeing you today?			

PERSONAL HEALTH HISTORY

ALLERGIES TO MEDICATIONS (please also include allergies to any food, latex, or anesthesia)

Name of Drug/Allergen	Reaction You Had

List your prescribed drugs AND over-the-counter drugs, such as vitamins, inhalers, non-prescription, herbal, or diet supplements.

Name of Drug	Strength	Frequency Taken

Check any medical conditions you have been diagnosed with.

<input type="checkbox"/> Allergies	<input type="checkbox"/> Atrial Fibrillation (A-Fib)	<input type="checkbox"/> Depression	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Benign Prostatic Hypertrophy (BPH)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Peptic Ulcer Disease
<input type="checkbox"/> Angina	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Renal Disease
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Cancer :	<input type="checkbox"/> GERD	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> COPD	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Thyroid Disease

Surgeries

Year	Reason	Hospital

Other Non-Surgical Hospitalizations

Year	Reason	Hospital

HEALTH HABITS AND PERSONAL SAFETY

EXERCISE	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
TOBACCO	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
DRUGS	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No
ALCOHOL	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	How much alcohol do you drink (per week)		
SEAT BELT USE	Do you wear your seat belt while riding in a vehicle?		<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY HEALTH HISTORY

Please list any problems that run in your family to include bad reactions to anesthesia, easily bruising or bleeding, diabetes, cancer, heart attack before age 55, arthritis etc.

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Mother				<input type="checkbox"/> M	
Sibling	<input type="checkbox"/> M		<input type="checkbox"/> F		
	<input type="checkbox"/> F		<input type="checkbox"/> M		
	<input type="checkbox"/> M		<input type="checkbox"/> F		
	<input type="checkbox"/> F		<input type="checkbox"/> M		
	<input type="checkbox"/> M		<input type="checkbox"/> F		
	<input type="checkbox"/> F		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
			Grandmother <i>Maternal</i>		
			Grandfather <i>Maternal</i>		
			Grandmother <i>Paternal</i>		
			Grandfather <i>Paternal</i>		

WOMEN ONLY

Date of last menstruation:	
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PREFERRED PHARMACY: _____ **PHONE NUMBER:** _____
ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIPCODE:** _____

Patient Name (Print) _____

Patient Signature: _____ **Date:** _____
 (parent or legal guardian if patient is a minor)