New Patient Health History Questionnaire

Name _____DOB _____Age _____
Marital Status _____Spouse's Name_____
Children (names/ages)
_____
_____

Date of last physical exam _____
Allergies _____
Education _____Years High School _____ Years College _____ Years Postgrad
Occupation _____ Company _____
Do you smoke? _____ How much? _____Smokeless tobacco use? _____
Do you drink alcohol? _____ How much? _____
Hobbies _____
Last tetanus shot date _____
Last pneumonia vaccine date _____
Last flu shot date _____
How did you hear about Family Medicine of Mt Pleasant?
_____

Personal Health History: circle any that apply to you.
Have you ever had…

Diabetes	Cancer	Heart Attack or Stents	Asthma
High Cholesterol	Stroke	Vascular Disease	High Blood Pressure
Pneumonia	Anemia	Meningitis	Migraine Headaches
Eczema	Psoriasis	Mononucleosis	Tuberculosis
Measles	Mumps	Chicken Pox	Whooping Cough
Thyroid Disorder	Arthritis	Sciatica	Fibromyalgia
Epilepsy	Osteoporosis	Depression	Bipolar Disorder

Pregnancies _____ Deliveries: Vaginal or Caesarean Section

Surgeries:
Appendectomy Tonsillectomy
Gallbladder Removal Blood Transfusion
Hysterectomy – reason for removal _____
Joint Replacement _____
Knee/Shoulder arthroscopy
Other _____

Injuries:
Severe Head Injury Sprains Lacerations
Broken Bones (please list)_____
Other _____

Do you have any other medical problems other than those listed above?_____

If yes, please list _____

_____

Hospitalizations: please list _____

Date: Reason:

Family History: Has any blood relative ever had the following?

	WHO		WHO
Thyroid Disease yes/no		Heart Disease/Heart Attack yes/no	
Cancer yes/no		High Blood Pressure yes/no	
Asthma yes/no		Stroke yes/no	
Arthritis yes/no		Diabetes yes/no	
Epilepsy yes/no		Kidney Trouble/Dialysis yes/no	
Depression yes/no		Aneurysms yes/no	
Substance Abuse yes/no		Suicide yes/no	
Other Familial Disorder:			