GREATER SANDHILLS FAMILY HEALTHCARE, P.C.
HEALTH QUESTIONNAIRE

Today's Date: _____

Please fill out as much of this form as possible. If you cannot answer some of the questions or feel uncomfortable answering them, leave them blank.

Name: _____ **Date of Birth:** _____

MEDICAL HISTORY **Current Medications (include over the counter medications and supplements)**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Medical Allergies _____

Please check to indicate if you have ever had the following conditions (note major injuries as other)

□ Diabetes	□ High blood pressure	□ Asthma	□ Heart Attack
□ Kidney Disease	□ Hepatitis	□ Thyroid disease	□ Heart Arrhythmia
□ Stroke	□ Depression or Anxiety	□ Emphysema	□ Seizure
□ Tuberculosis	□ Coronary Artery Disease	□ Migraines	□ High Cholesterol/lipids
□ Chronic Obstructive Pulmonary Disease (COPD)		□ Dementia	□ Congestive Heart Failure

□ Eye Problems, Type: _____ □ Cancer, Type: _____
□ Sexually transmitted disease, Type: _____
□ Other, please explain: _____
_____

Did you have any major medical problems at birth? □ No □ Yes _____

Please list any surgeries or hospital stays you have had and their approximate date/ year:

Type of surgery/reason for hospitalization, please specify right vs left, etc *Date*

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you currently receiving care from any other doctors (specialists), chiropractors, or other health care professionals? If yes, we would like to know whom so that we can coordinate your care:

Provider's Name *Condition they are treating you for*

_____ _____
_____ _____
_____ _____

Please note dates of your most recent immunizations (if known):

	Approximate Date		Approximate Date		Approximate Date
Tetanus	_____	Influenza	_____	Gardasil	_____
Pneumonia	_____	Meningitis	_____	Shingles	_____

If you have had any of the following tests done, please note when they were done, if known:

Test	*Approximate Date*	*location lab or procedure was done*
Basic blood work	_____	_____
Pap smear/ pelvic	_____	_____
Mammogram	_____	_____
Colonoscopy	_____	_____
Prostate blood test	_____	_____
Bone Density Scan	_____	_____

FAMILY HISTORY Please indicate any of the following family history (parents, siblings, grandparents)

□ Epilepsy/Seizure _____ □ Osteoporosis _____ □ Auto-Immune Disease _____

□ Migraine _____ □ Arthritis _____ □ Anemia/Blood Cell disorder _____

□ Glaucoma _____ □ Heart Disease _____ □ Bleeding/Clotting disorder_____

□ Diabetes _____ □ Stroke _____ □ High Blood Pressure _____

□ Asthma _____ □ Hepatitis _____ □ High Cholesterol _____

□Cancer _____ □ Alcoholism _____ □ Thyroid Disease _____

□ Depression/Anxiety _____ □ Mental Illness _____

HEALTH HABITS

Do you smoke or use any tobacco products?..... □ Yes □ No □ Quit

Number of cigarettes each day? _____ For how many years? _____

Other forms of tobacco used: _____

Do you drink alcohol?..... □ Yes □ No □ Quit

How much? _____ How often? _____

Have you ever felt that you should cut down on your drinking?..... □ Yes □ No

Have you regularly used drugs?..... □ Yes □ No

If yes, are you still using them? _____ What is the name of the drug(s)?_____

PERSONAL HISTORY

Are you currently married?.....□ Yes □ No □ Single □ Divorced

Are you employed?..... □ Yes □ No If yes, what is your occupation? _____

WOMEN ONLY

Have you ever been pregnant?..... □ Yes □ No How many times?___

Miscarriages ___ Abortions ___ How many children do you have living? ___

Patient signature _____Date:_____Rev.3/22/18