Chantilly Family Practice Center

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HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

	Self	Family		Self	Family		Self	Family
Cancer	❑	❑	Allergy	❑	❑	Gall Stones	❑	❑
Heart Disease	❑	❑	Joint or Bone Problem	❑	❑	Hepatitis	❑	❑
Angina	❑	❑	Osteoporosis	❑	❑	Liver Disease	❑	❑
High Blood Pressure	❑	❑	Arthritis	❑	❑	Thyroid Disease	❑	❑
High Cholesterol	❑	❑	Gout	❑	❑	Skin Disease	❑	❑
Stroke	❑	❑	Kidney Disease	❑	❑	AIDS	❑	❑
Diabetes	❑	❑	Bladder Infection	❑	❑	Sexually Transmitted Disease	❑	❑
Obesity	❑	❑	Bleeding Disorder	❑	❑	Depression	❑	❑
Lung Disease	❑	❑	Sickle Cell	❑	❑	Suicide	❑	❑
Tuberculosis	❑	❑	Anemia	❑	❑	Alcoholism / Drug Addiction	❑	❑
Emphysema	❑	❑	Blood Clots	❑	❑	Glaucoma	❑	❑
Chronic Bronchitis	❑	❑	Colitis	❑	❑	Seizure / Epilepsy	❑	❑
Asthma	❑	❑	Ulcers	❑	❑	Other	❑	❑

List medications you take (prescriptions and non-prescriptions) and the dosage:

_____

List allergies to medications/ foods, etc.:

_____

Have you ever had any surgeries? ❑ YES ❑ NO

If yes, please list name and year:

_____

_____

Do you have a Healthcare living will/Durable power of Attorney?

❑ YES ❑ NO

If yes, have you given a copy to your physician? ❑ YES ❑ NO

Are you an organ donor? ❑ YES ❑ NO

Do you always wear your seatbelt while traveling? ❑ YES ❑ NO

Do you have a smoke detector? ❑ YES ❑ NO

Do you have any health concerns? _____

_____

❑ Check if you would like information on sexually transmitted diseases.

IMMUNIZATIONS

Have you had a Tetanus shot in the last 10 years? ❑ YES ❑ NO

Have you had a Pneumoccal vaccine? (65 & over) ❑ YES ❑ NO

Do you receive a flu shot annually? ❑ YES ❑ NO

Have you had a measles booster? ❑ YES ❑ NO