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):	☐ M ☐ F	**DOB:**
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ 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.

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

Surgeries

Year	Reason	Hospital

Other Non-Surgical Hospitalizations

Year	Reason	Hospital

HEALTH HABITS AND PERSONAL SAFETY

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

WOMEN ONLY

Date of last menstruation:		
Are you pregnant or breastfeeding?	☐ Yes	☐ No

PREFERRED PHARMACY: _____ **PHONE NUMBER**: _____

ADDRESS:_____**CITY**:_____**STATE**_____**ZIPCODE**:_____

Patient Name (Print)_____

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