VALLEY-WIDE HEALTH SY STEMS, 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/Food/Allergen	Reaction you had	Name of Drug/Food/Allergen	Reaction you had

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

Name of drug	Strength	Frequency/how often Taken

Check any medical conditions you have been diagnosed with

☐ Allergies	☐ Chemtherapy (*growth, tumor or other condition*)	☐ Blood Thinner Medication	☐ Peptic Ulcer Disease
☐ Anemia	☐ COPD	☐ Hepatitis C.	☐ Pregnant
☐ Angina	☐ Coronary Artery Disease	☐ High Blood Pressure	☐ Renal Disease
☐ Anxiety	☐ Depression	☐ High Cholesterol	☐ Rheumatoid Arthritis
☐ Arthritis	☐ Diabetes	☐ Irritable Bowel Syndromes (IBS)	☐ Radiation therapy *(growth, tumer or other condition)*
☐ Asthma	☐ Gallbladder Disease	☐ Liver Disease	☐ Seizer Disorder
☐ Atrial Fibrillation	☐ GERD Gastroesphageal Reflex Disease	☐ Migraine Headaches	☐ Steroids (e.g. Cortisone): *Taking or taking (within the last 2 years)*
☐ Benign Prosthetic Hypertrophy (BPH)	☐ Heart Attack	☐ Nursing an Infant	☐ Stroke
☐ Blood Clots	☐ Congenital Heart Defect	☐ Organ Transplant	☐ Difficult to Swallow
☐ Bruise or Bleed Easily	☐ Congenital Heart Disease	☐ Orthopedic Total Joint Replacement *(e.g. hip, knee, elbow, finger, toe)*	☐ Thyroid Disease
☐ Cancer	☐ Heart Valve Artificial or Prosthetic Material	☐ Osteoarthritis	☐ Jaw Pain
☐ Bisphosphonates Medication (*for Osteoporosis or Chemotherapy*) **Oral or Intravenous**: Have you taken, taking currently or scheduled to take	**Current & Past Substance/Alcohol** ☐ Alcohol ☐ GHB ☐ Marijuana ☐ Cocaine ☐ Inhalants ☐ Vaping	**Current & Past Substance/Alcohol** ☐ Heroin ☐ Hallucinogens ☐ MDMA/Ecstasy ☐ Ketamine ☐ Methamphetamines	☐ Other

Surgeries: Medical or Dental		
Year of Surgery	Reason for Surgery	Which Hospital

Other Non-Surgeries Hospitalizations		
Year of Visit	Reason for Hospitalization	Which Hospital or Clinic

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/VAPING	Do you vape/vaping? Yes No Do you use tobacco?	Yes	No
	Cigarettes – pks./day | Chew cans/pouches #/day | Pipe - #/day | Cigars - #/day		
	# of years | Or year you 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.

	Gender	Age	Signfiicant Health Problems		Gender	Age	Signfiicant 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**			

Date of Last Menstration:	Are you pregnant or breastfeeding? ☐ Yes ☐ No
Preferred Pharmacy Name:	Phone:
Pharmacy Address:	City Zip

Print Patient Name: _____ **Today's Date:** _____

Patient Signature _____ **Print Name:** _____
(Parent/Legal Guardian If patient a minor) **Parent or minor's Guardian**