SPRINGTOWN FAMILY HEALTH CENTER

HEALTH QUESTIONAIRE

NAME: _____ **DATE OF BIRTH:** _____ **TODAY'S DATE** _____

ALLERGIES:

_____ _____ _____

_____ _____ _____

CURRENT MEDICATIONS:

_____ _____ _____

_____ _____ _____

_____ _____ _____

MEDICAL PROBLEMS:

( ) A-Fib ( ) Allergies ( ) Anemia ( ) Angina ( ) Arthritis ( ) Asthma ( ) Cancer ( ) CHF ( ) Clotting disorders ( ) COPD
( ) Colon Polyps ( ) Dementia ( ) Depression ( ) Diabetes ( ) Diverticulosis ( ) Eczema ( )GERD ( ) Glaucoma
( ) Gout ( ) Heart disease ( ) Hepatitis ( ) Hiatal Hernia ( )Hypertension ( )High cholesterol ( )Kidney Stones
( )Migraines ( )Osteoporosis ( )Parkinsons ( )Psoriasis ( ) Renal Insufficiency ( )Seizures ( ) Stroke ( )Thyroid problems

_____ _____ _____

_____ _____ _____

_____ _____ _____

PAST SURGICAL HISTORY:

_____ _____ _____

_____ _____ _____

_____ _____ _____

FAMILY HISTORY:

( ) Allergies ( ) Anemia ( ) Arthritis ( ) Asthma ( ) Cancer ( ) Clotting disorders ( ) Depression
( ) Diabetes ( ) Glaucoma ( ) Heart Disease ( ) Hepatitis ( ) Hypertension ( ) High Cholesterol ( ) Migraines
( ) Osteoporosis ( ) Parkinson's ( ) Psoriasis ( ) Seizures ( ) Stroke ( ) Thyroid

SOCIAL HISTORY:

SMOKER? ( ) YES ( ) NO PREVIOUS SMOKER? ( ) YES ( ) NO CIG PER DAY _____ YEARS_____
ALCOHOL USE ( ) YES ( ) NO NUMBER OF DRINKS PER DAY_____ / PER WEEK _____
DRUG USE ( ) YES ( ) NO TYPE_____ PREVIOUS USE? ( ) YES ( ) NO
( )MARRIED ( ) SINGLE ( )DIVORCED ( )WIDOWED
Occupation: _____
BIRTH CONTROL? ( )YES ( ) NO TYPE OF BIRTH CONTROL:_____
Pregnancy #:_____ Children #:_____

SCREENING EXAMS:(please indicate date)

Colonoscopy: _____ Polyps? ( ) YES ( ) NO PSA level:_____
Mammogram:_____ Bone Density:_____ Pap:_____
Pneumonia Vaccine:_____ Shingles Vaccine:_____ Tetanus Vaccine:_____