

# Klamath Health Partnership: Health History Questionnaire

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

<b>Past Medical History: Please write in box below</b>		<b>Hospitalizations: Please include dates</b>	
<b>Past Surgical History: Please include dates</b>		<b>Drug Allergies: List the drug and what reaction you had</b>	
<b>Current Medications: Prescription, non-prescription, vitamins, herbs</b>			
<b>Medication</b>	<b>Dose (mg, pill)</b>	<b>Times per day</b>	<b>Reason for Taking</b>
<b>Social History</b>		<b>Family History</b>	
<b>Tobacco Use</b> * Cigarettes: <input type="checkbox"/> Never <input type="checkbox"/> Quit Date: _____ <input type="checkbox"/> Current Smoker: packs/day _____ # of yrs _____ * Other: <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Snuff <input type="checkbox"/> Chew Are you interested in quitting? <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Alcohol Use</b> Drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes # drinks/wk _____ Is alcohol use a concern for you or others? <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Drug Use</b> Do you use any recreational drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please list: _____		Please note any serious health conditions for: Your Mother: _____ Your Father: _____ Siblings: _____ Maternal Grandma: _____ Maternal Grandpa: _____ Paternal Grandma: _____ Paternal Grandpa: _____	
<b>Occupation:</b> _____		<b>Immunizations: Date of your most recent immunization</b>	
<b>Hobbies:</b> _____		Tetanus (Td) _____ Tetanus & pertussis _____ Pneumonia _____ Influenza (flu) _____	
<b>Health Maintenance Screening Tests: Give dates</b>		<b>Other Providers</b>	
Sigmoidoscopy: _____ Abnormal? <input type="checkbox"/> N <input type="checkbox"/> Y Colonoscopy: _____ Abnormal? <input type="checkbox"/> N <input type="checkbox"/> Y Men: PSA (prostate) _____ Abnormal? <input type="checkbox"/> N <input type="checkbox"/> Y		Last Dental Visit _____  List other doctors you see & why (what health condition): _____	
Women: Please give dates: Mammogram: _____ Abnormal? <input type="checkbox"/> N <input type="checkbox"/> Y Pap Smear: _____ Abnormal? <input type="checkbox"/> N <input type="checkbox"/> Y Bone scan: _____ Abnormal? <input type="checkbox"/> N <input type="checkbox"/> Y  # pregnancies _____ # deliveries _____ # abortions _____ # miscarriages _____ Last period: _____			