HEALTH HISTORY QUESTIONNAIRE

Name:	**DOB:**
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Occupation:	☐ Retired ☐ Unemployed ☐ Employed; full time ☐ Employed; part time ☐ Student

List any medical problems that other doctors have diagnosed you with			
□ Atrial fibrillation	□ Heart attack	□ Kidney Disease	
□ Atrial Flutter	□ Congestive Heart Failure	□ Lung Disease	
□ Diabetes	□ Stroke	□ Cancer	
□ Hypertension	□ Coronary Artery Disease	□ Pacemaker or Defibrillator	
□ Sleep Apnea	□ Arthritis		
□ COPD	□ High Cholesterol		

Have you had any past surgeries or been hospitalized in the last year		
Year:	Reason:	Hospital:

List any <u>significant family medical history</u> such as heart disease, diabetes, hypertension, stroke, heart rhythm problems.
Father:
Mother:
Grandparents:
Siblings:

List medications:			
List allergies to medications or food:			

Last flu shot				
Last pneumonia shot				
Last physical exam				
Exercise	☐ Rarely or never exercise		☐ Frequently exercise	
	☐ Occasional exercise		☐ Exercise daily	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?			☐ Yes ☐ No
	If yes, how many drinks per day/week?			
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