Holvik Family Health Center

Health Questionnaire

Name: _____ D.O.B.:_____

The confidential answers you give on this form will provide important background information for your doctor. Feel free to discuss any questions with the doctor. Please answer all questions to the best of your recollection.

Medical History

Past Medical Problems (examples: measles, chicken pox, hepatitis, pneumonia, heart attack, stroke, etc.)

1._____ 4._____
2._____ 5._____
3._____ 6._____

Current Medical Problems: (examples: asthma, diabetes, high blood pressure, headaches, cancer, AIDS, etc.)

1._____ 4._____
2._____ 5._____
3._____ 6._____

Operations: (examples: appendectomy, c-section, gallbladder, Hysterectomy, tonsillectomy, etc.)	Dates	Serious Injuries: (examples: auto accident, hernia, fractures, wounds, head injuries, etc.)	Dates

Hospitalizations:

Name: _____ D.O.B.:_____

Name of Current Pharmacy: _____ **Location:** _____

Medications: List all medication you currently take. (include prescription medications, vitamins, aspirin, over the counter medication, cold remedies, birth control pill, etc)

Allergies to Medications	**Reactions**

Health Habits	**Yes**	**No**	**How much per day**
Do you drink alcohol?			
Do you smoke or use tobacco?			Quit when:
Do you use caffeine?			
Do you use illegal drugs?			Type: Amount:

What type of exercise do you get? _____

Menstrual History (Women only): Age of first menstrual period _____ Number of Pregnancies _____
Number of Children _____

Marital Status: Single _____ Married _____ Widower _____ Separated _____ Divorced _____

Occupation: _____ Employed: Yes No Student: Yes No Retired: Yes No

Highest level of education: _____ Hobbies: _____

Family History
List all immediate family members

	Living	Deceased	Age	List major medical problems and things that run in the family
Father				
Mother				