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**Original Date:**

**Dates Revised:**

# HEALTH HISTORY QUESTIONNAIRE

*All questions contained in this questionnaire are strictly confidential and will become part of your medical record.*

| **Name** *(Last, First, M.I.):* ☐ M ☐ F | **DOB:** |
|---|---|
| **Marital status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | **OCCUPATION:** |
| **Previous or referring doctor:** | **Date of last physical exam:** |

## PERSONAL HEALTH HISTORY

**Childhood illness:** ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

| **Immunizations and dates:** | | |
|---|---|---|
| | ☐ Tetanus | ☐ Pneumonia |
| | ☐ Hepatitis | ☐ Chickenpox |
| | ☐ Influenza | ☐ MMR *Measles, Mumps, Rubella* |

**List any medical problems that other doctors have diagnosed:**

1.____________________________________________________________

2.____________________________________________________________

3.____________________________________________________________

4.____________________________________________________________

5.____________________________________________________________

6.____________________________________________________________

***HAVE YOU EVER BEEN ALLERGY TESTED BEFORE?** ☐ YES OR ☐ NO BY DR.__________________ DATE OF TEST:______________

### SURGERIES

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |

### OTHER HOSPITALIZATIONS

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |

| **Are you under the care of a Physician for recent or current injuries, illness, or conditions?** | Yes | No |
|---|---|---|

**Patients Birth History:**

**Born natural birth or C-Section**? ____________________________________ **Born**: (circle one) ☐ On time ☐ Premature ☐ Over due date

**Breast Fed**? ☐ Yes or ☐ No How long?______________ **Hospitalized at Birth**? ☐ Yes or ☐ No How long?____________

## HEALTH HABITS AND PERSONAL SAFETY

*ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL AND WILL BECOME PART OF YOUR MEDICAL RECORD.*

| | | | | | |
|---|---|---|---|---|---|
| **LIST CURRENT MEDICATIONS** (may use Additional Sheet) | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| | | | |
|---|---|---|---|
| **Diet** | Have you experienced food allergies? | ☐ Yes | ☐ No |
| | Have you ever been tested for food allergies? | ☐ Yes | ☐ No |
| | List food allergies: (confirmed or suspected) | | |

| | | | | |
|---|---|---|---|---|
| | 1 | 4 | 7 | 10 |
| | 2 | 5 | 8 | 11 |

| | | | |
|---|---|---|---|
| *Alcohol* | Do you drink alcohol? | ☐ Yes | ☐ No |
| | Number of drinks per week? | | |
| **DRUG ALLERGIES**<br><br>**List reactions of each medication** | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| **Tobacco** | Do you use tobacco? | ☐ Yes | ☐ No |
| | ☐ Cigarettes – packs per day | ☐ Chew - #/day | ☐ Pipe - #/day | ☐ Cigars - #/day |
| | ☐ # of years _________ | ☐ Or year quit __________________ | Second hand smoke? ☐ Yes | ☐ No |
| **Drugs** | Do you currently use recreational or street drugs?<br>What drug:___________________ ___________________ | ☐ Yes | ☐ No |
| | Have you ever given yourself street drugs with a needle? | ☐ Yes | ☐ No |

## FAMILY HISTORY OF ALLERGIES OR ASTHMA

| | AGE | ALLERGIES, ASTHMA, REOCCURRING INFECTIONS | Child's Name | AGE | ALLERGIES, ASTHMA, REOCCURRING INFECTIONS |
|---|---|---|---|---|---|
| **Father** | | | | ☐ 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* | | |

**DO YOU/PATIENT EXPERIENCE REOCCURRING SINUS, LUNG, OR EAR INFECTIONS? ☐ YES OR ☐ NO**

**HOW MANY TIMES PER YEAR?___________________ DURING WHAT SEASON OR CLIMATE?________________________________**

# ADDITIONAL PROBLEMS...

| | | |
|---|---|---|
| ☐ Skin | ☐ Chest/Heart | ☐ Recent changes in: |
| ☐ Head/Neck | ☐ Back | ☐ Weight |
| ☐ Ears | ☐ Intestinal | ☐ Energy level |
| ☐ Nose | ☐ Bladder | ☐ Ability to sleep |
| ☐ Throat | ☐ Bowel | ☐ Other pain/discomfort: |
| ☐ Lungs | ☐ Circulation | |

| | | |
|---|---|---|
| **Do you own pets?**<br>**Type of pet: ☐ Dog ☐ Cat ☐ Rabbit ☐ Rodent ☐ Reptile ☐ Bird Other:__________________** | **☐ Yes** | **☐ No** |
| If you own pets, are they allowed in sleeping areas of home? | ☐ Yes | ☐ No |
| Do you have trouble sleeping? | ☐ Yes | ☐ No |
| Do you use a HEPA-filter vacuum or air purifier in your home? | ☐ Yes | ☐ No |
| Do you use feather pillows, comforters, or other bedding to sleep with? | ☐ Yes | ☐ No |
| Do you use air-conditioning in your home? | ☐ Yes | ☐ No |
| Do you have carpeting in your home? | ☐ Yes | ☐ No |
| What is the age of your current home? | Yrs. | Mo. |
| How long have you lived in your current home? | Yrs. | Mo. |
| **TYPE OF HEATING IN HOME: (SELECT ONE) ☐ FORCED-AIR ☐ GAS ☐ ELECTRIC ☐ WOOD ☐ IN FLOOR**<br>**OTHER:__________________** | | |

| | | |
|---|---|---|
| Have you experienced issues with rodents or pests in your home? | ☐ Yes | ☐ No |
| Do you have issues (past or present) with mold and mildew evidence or buildup in your home? | ☐ Yes | ☐ No |
| Do you have a basement in your home? | ☐ Yes | ☐ No |
| Do you experience limitations when symptoms are experienced? | ☐ Yes | ☐ No |
| Does your job keep you indoors? | ☐ Yes | ☐ No |
| Do you work outdoors? | ☐ Yes | ☐ No |
| Do you travel frequently with school, work, or leisure? | ☐ Yes | ☐ No |
| Do you work in polluted work environments? | ☐ Yes | ☐ No |
| Hobbies: ______________________ ________________________ ________________________<br>______________________ ________________________ ________________________ | ☐ Yes | ☐ No |

**STUNG BY INSECTS? ☐ YES OR ☐ NO WHAT KIND OF INSECT(S) ____________________ ☐ BITTEN OR ☐ STUNG?**

RESULT: (check one) ☐ HIVES ☐ PASS-OUT ☐ SHORTNESS OF BREATH ☐ SCARED FEELING ☐ OTHER:__________________________

**HAVE YOU EXPERIENCED REACTION TO LATEX OR ADHESIVES? ☐ YES OR ☐ NO**

RESULT: ____________________________________________________________________________________________

Pharmacy Name:__________________________Location:______________________________Phone number:_____________________________

Patient Name:__________________________________________________DOB:_________________________ACCT#______________________