MTN. VIEW FAMILY PRACTICE, P.C.
HEALTH QUESTIONNAIRE

Patient Name: _____ **Pharmacy Name:** _____
Date of Birth: _____ **Pharmacy #:** _____
Pharmacy Fax: _____
Date of Visit: _____

Please use back of page for additional writing space

Reason for Visit:

FAMILY HISTORY IF ANY **FAMILY MEMBERS** HAS /HAD ILLNESS - BELOW – PLEASE CIRCLE & provide Details : Moth - Fath - Grandparents

1) Alcoholism	7) Cholesterol	13) Hepatitis	19) Stroke
2) Alzheimers	8) Diabetes	14) Headache	20) TB
3) Anemia	9) Epilepsy	15) Lung Disease	21) Thyroid Disease
4) Arthritis	10) Eye problems	16) Mental Illness	22) Migraine
5) Asthma	11) Heart Disease	17)Osteoporosis	23) Cancer
6) Bleeding/Clotting	12) Hypertension	18) Stomach	24) Other _____

Details of Family History:

HOSPITAL ADMISSIONS	YEAR	ILLNESS or OPERATION	YEAR	ILLNESS or OPERATION

LIST ALL MEDICATIONS and VITAMIN-HERBAL SUPPLEMENTS

NAME	DOSE	NAME	DOSE

ALLERGIES

VACCINE/date

Anthrax	
Chicken Pox	
Hepatitis (A/B):	
HPV/Cervical CA	
Influenza:	
Measles- MMR	
Meningitis:	
Pneumovac;	
Tetanus:	

TEST/EXAM/date

Chest X-ray:
Cholesterol:
Colonoscopy;
Diabetes
Dental: Eye:
Bone Density
Prostate:
Tuberculosis:
Other Tests

MEDICAL HISTORY MARK "C" FOR CURRENT PROBLEMS (6 Month or Less), "X" for OLD or PREVIOUS HEALTH PROBLEMS.

HEAD and NECK
- ☐ Dizzy Spells/Vertigo
- ☐ Fainting
- ☐ Hay fever/Allergies
- ☐ Headaches
- ☐ Hearing Problem ☐ Ringing in ear
- ☐ Hoarseness – *prolonged*
- ☐ Nose Bleeds – *recurrent*
- ☐ Seizures
- ☐ Stroke
- ☐ Sinus Trouble
- ☐ Sore Throats – *frequent*
- ☐ Vision Problems ☐ Eye Pain

LUNG and RESPIRATORY System
- ☐ Asthma
- ☐ Chronic cough
- ☐ Pleurisy ☐ Chest Pain
- ☐ Pneumonia
- ☐ Rib Fracture
- ☐ Shortness of Breath
  - ☐ On Exertion, ☐ Laying down, ☐ @ Rest

CARDIO-VASULAR System
- ☐ Aneurysm
  - ☐ Chest-Abdomen ☐ Brain
- ☐ Chest Pain
- ☐ Heart Attack Date:
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Leg Pain
  - Cold or Numb; ☐ Hands ☐ Feet
- ☐ Palpitations ☐ Irregular Pulse
- ☐ Swollen legs or ankles
- ☐ Varicose Veins/Phlebitis

GASTROINTESTINAL
- ☐ Heartburn ☐ Stomach Ulcer
- ☐ Nausea/Vomiting ☐ Gallbladder Dis
- ☐ Abdominal Pain - *chronic*
- ☐ Jaundice/Hepatitis
- ☐ Diarrhea ☐ Constipation
- ☐ Diveritculosis ☐ Crohn's/Colitis
- ☐ Bloody or Black Tarry Stools
- ☐ Hemorrhoids ☐ Hernia
- ☐ Worms ☐ Parasites
- ☐ Difficulty Swallowing ☐ Poor Appetite
- ☐ Weight: ☐ Loss ☐ Gain
- ☐ Bloody or Black Tarry Stools

URO-GENITAL System
- ☐ Problems Urinating
  - ☐ More than 8 times/24 hrs
  - ☐ Overnight more than twice
  - ☐ Stress incontinence
  - ☐ Urgency to urinate ☐ with leakage
- ☐ Blood in urine
- ☐ Kidney Stones
- ☐ Urine Infections ☐ Prostate Prob
- ☐ Bed Wetting
- ☐ Prostate Problems
- ☐ Other _____

Women's Health
Date of Last PAP test _____
☐ Normal ☐ Abnormal _____(Date)
Pregnancies _____ Births_____
☐ Birth Control - Method_____
Date of Last Mammogram _____
☐ Normal ☐ Abnormal
☐ Menopause Date_____

BONES_ JOINTS -MUSCLE- SKIN
- ☐ Arthritis/Rheumatism
- ☐ Back Pain
- ☐ Bone Fracture/Joint Injury
- ☐ Gout
- ☐ Osteoporosis/Osteopenia ☐ Gout
- ☐ Rashes ☐ Hives
- ☐ Psoriasis ☐ Eczema
- ☐ Poor Wound Healing
- ☐ Tremor ☐ Numbness

ENDOCRIN or HORMONE Disorders
- ☐ Diabetes ☐ Thyroid Disease
- ☐ Hair Loss
- ☐ Hormonal Supplements
- ☐ Menopause
- ☐ Other;

MENTAL HEALTH
- ☐ Anxiety ☐ Depression
- ☐ Weight: ☐ Loss ☐ Gain
- ☐ Concentration Prob ☐ Memory Loss
- ☐ Moodiness
- ☐ Decreased Life Enjoyment
- ☐ Decreased Work Performance
- ☐ Sexual Problems/Enjoyment
- ☐ Sleep Problems ☐ Waking Fatigued
  - ☐ Falling to sleep ☐ Staying asleep
  - ☐ Sleeping Too Much ☐ Bad Dreams
- ☐ Phobias
- ☐ Thoughts of; ☐ Suicide ☐ Self Harm
- ☐ Previous Hospitalizations ; Mental Health
  Date_____.Reason _____
- ☐ Other;

INFECTIONS
- ☐ Herpes ☐ Aids/HIV ☐ STD
- ☐ MRSA (Skin infection)
- ☐ Rheumatic Fever ☐ Measles
- ☐ Chicken Pox ☐ Polio ☐ Mumps
- ☐ Tuberculosis
- ☐ Hepatitis

BLOOD DISORDERS
- ☐ Anemia
- ☐ Easy Bleeding, ☐ Easy Bruising
- ☐ Fatigue/Loss of Energy
- ☐ Leukemia // Blood Cancer
- ☐ Blood Transfusions
- ☐ Other

Personal History
- ☐ Alcohol _____oz. Per Week
- ☐ Coffee/Tea _____ cups per day
- ☐ Exercise _____ times per week
- ☐ Toxic Exposure
  - ☐ Chemical _____
  - ☐ Radiation _____
  - ☐ Asbestos _____
  - ☐ Other _____

Tobacco Use
- ☐ # Cig per Day _____
- ☐ # Years at above level_____
- ☐ Year quit _____
- ☐ Street Drugs _____
  - ☐ IV-IM
  - ☐ Inhalants
- ☐ Previous Cancers (self)
  Type;
  Year diagnosed