Date: _____/_____/_____

HEALTH HISTORY QUESTIONNAIRE

Name: *(Last, First, M.I.)* ☐ **M** ☐ **F**	**DOB** _____/_____/_____

Height: **Weight:** **Name of Pharmacy:** **Phone:**

Referring Physician: **Primary Care Physician:**

Other Physicians:

Advance directive? ☐ Yes ☐ No

PERSONAL HEALTH HISTORY

Main Reason for Today's Visit:

Flu vaccine? ☐ **No** ☐ **Yes, Date:** _____ **Pneumococcal vaccine?** ☐ **No** ☐ **Yes, Date:** _____

List ALL Current medications:

Name:	**Strength:**	**Qty:**	**Frequency:**

Please list any Medical Issues that have been diagnosed by other doctors:

Allergies to Medications:	
Name:	Reaction:

Surgeries:		
Year:	Reason:	Hospital:

Hospitalizations:		
Year:	Reason:	Hospital:

	Alive/deceased	Significant Health Problems or Cause of Death
Father		
Mother		
Siblings		
Children		
Grandparents		

HEALTH HABITS and SOCIAL HISTORY

Exercise: ☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
☐ Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min.)
☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Caffeine: ☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day? _____

Alcohol: Do you drink alcohol? ..... ☐ Yes ☐ No
If yes, what kind?_____ How many drinks per week? _____

Tobacco: Are you a: ☐ Former Smoker ☐ Current Smoker ☐ Never smoked
☐ Cigarettes - Pks/day_____ ☐ Chew - #/day _____ ☐ Pipe - #/day _____
☐ Cigars - #/day _____ ☐ # of Years _____ Year Quit _____

Social History: Where were you born and raised? _____
Occupation: _____
Occupational hazards or exposures: _____

Please answer the following questions.

Do you or has someone told you that you snore or stop breathing in your sleep? ..... ☐ Yes ☐ No
Have you ever woken up choking or gasping for air? ..... ☐ Yes ☐ No
Any memory loss, irritability, or difficulty concentrating? ..... ☐ Yes ☐ No
Do you find yourself increasingly tired during the day? ..... ☐ Yes ☐ No
Do you have a crawling sensation or restless legs? ..... ☐ Yes ☐ No
Do you or have you been told that you kick your legs frequently at night? ..... ☐ Yes ☐ No

REVIEW OF SYSTEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Depression _____
☐ Stress/Anxiety _____
☐ Head/Neck _____
☐ Ears/Nose/Throat _____
☐ Lungs _____
☐ Chest/Heart _____
☐ Intestinal _____
☐ Bladder _____

Recent Changes In:

☐ Weight _____
☐ Energy Level _____
☐ Ability to Sleep _____

Other Issues Not Mentioned Above:

_____
_____
_____

Epworth Sleepiness Scale: Use the scale to rate each situation. **Circle** your level of sleepiness.

0 = wide awake; 1 = slight chance of sleepiness; 2 = moderate chance of sleepiness; 3 = high chance of sleepiness

Sitting and reading	_____	Lying down to rest in afternoon	_____
Watching television	_____	Sitting quietly after lunch	_____
Sitting inactive in public place	_____	Sitting and talking to someone	_____
Passenger in car for more than 1 hour	_____	In a car, stopped in traffic	_____