Family Medicine of Washington County **Health Questionnaire**

Name:_____ DOB:_____ Date:_____

Past Medical and Family History (please specify family member)**:**

	SELF	FAMILY		SELF	FAMILY
Recent Weight Loss			Kidney/Bladder Problems		
Migraine Headaches			Neurological Problems		
Epilepsy/Convulsions			Arthritis		
Eye Disease			Osteoporosis		
Hearing Disorder			Cancer (please specify type)		
Recurrent Nose Bleeds					
Recurrent Sinus/Throat Infections			Bleeding Disorder		
Angina – Chest Pain			Blood Transfusions(s)		
Heart Attack			Anemia		
High Blood Pressure			Diabetes		
Stroke			Thyroid Disorder		
High Cholesterol			Alcohol/Drug Abuse		
Heart Valve Disorder			Mental Illness		
Lung Disease			Depression/Anxiety		
Stomach Ulcer			Psoriasis/Eczema		
Bowel Problems			Hair Loss		
Liver Disease/Hepatitis			Accident - Major		n/a

Hospitalizations/Surgeries:

YEAR	ILLNESS/OPERATION	YEAR	ILLNESS/OPERATION

CURRENT MEDICATIONS (include all prescriptions, vitamins and OTC's):

MEDICATION	DOSE	FREQUENCY

Do you NOW ***OR*** Have you EVER consumed any of the following:

Cigarettes	Y N	Daily Amt_____#Yrs_____
Alcohol	Y N	Drinks/Week_____
Caffeine	Y N	Cups/Day_____
Drugs	Y N	Type_____

The LAST time (YEAR) you had the following:

Flu Vaccine(type?)_____ TB test_____

Pneumonia Vaccine_____ Type _____

TB Test_____ HBsAg B Vaccine_____, _____, _____

Tetanus Shot_____ Tdap_____

Stool Blood Test_____ PSA_____

Cholesterol Test_____ Colonoscopy_____

Dental Exam_____ Eye Exam _____

Bone Density Exam_____ Normal Abnormal

For WOMEN Only

Last Breast Exam____ Monthly Self Exams Y N

Last Pap_____ Normal Abnormal

Last Mammogram_____ Normal Abnormal

Drug, Latex and/or Dye Allergies

ALLERGEN	REACTION

ADVANCE DIRECTIVES

Living Will: Y N DNR: Y N

DPOA: Y N

For WOMEN Only

Date of Last Menstrual Period:

Birth Control: Y N

Type:_____

How Many:

Pregnancies:_____

Births:_____

Abortions:_____

Miscarriages:_____