# FAMILY MEDICINE HEALTH - HISTORY QUESTIONNAIRE

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

| **First Name:** | **Last Name:** | **Date of Birth:** |
|---|---|---|
| **Previous or referring provider:** | | **Date of last physical exam:** |
| **REASON FOR YOUR VISIT TODAY:** | | |

## PERSONAL HEALTH HISTORY

**List any medical problems that you have been diagnosed with or treated for:**

**Allergies to Medications**

| Name of Drug | Reaction you had |
|---|---|
| | |

**List your current prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**

| Name of Drug | Strength | Frequency Taken |
|---|---|---|
| | | |

## FAMILY HEALTH HISTORY

Do any family members have significant health problems? ☐ Yes ☐ No If yes please list.

## WOMEN ONLY

| | | |
|---|---|---|
| Date of last menstruation: | | |
| Number of pregnancies ______ Number of live births ______ | | |
| Are you pregnant or breastfeeding? | ☐ Yes | ☐ No |
| Date of last pap exam? Date of last mammogram? | | |

## MEN ONLY

| | | |
|---|---|---|
| Do you usually get up to urinate during the night? | ☐ Yes | ☐ No |
| If yes, # of times ______ | | |
| Do you have any problems emptying your bladder completely? | ☐ Yes | ☐ No |
| Date of last prostate and rectal exam? | ☐ Yes | ☐ No |

Patient/Guardian Signature: ________________________________________ Date: ______________________

With this signature I verify that all the information given is current and up to date.