FAIRFAX FAMILY
PRACTICE CENTERS

Health History Questionnaire

Name: _____ Date of Birth: _____ Date: _____

ALLERGIES

List any allergies to medicines or foods

Medication/Food/Other Reaction

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

MEDICATIONS

Include prescription and non-prescription

Medication Dose Frequency

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

MEDICAL PROBLEMS

Check the box for any chronic or recurrent medical problems

- ☐ None
- ☐ Abnormal pap smear
- ☐ Alcohol or drug use
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Bladder Infection
- ☐ Bleeding/Clotting Disorder
- ☐ Bowel or Colon Disease
- ☐ Cancer - Type:_____
- ☐ Concussion
- ☐ Depression
- ☐ Diabetes - Onset: _____
- ☐ Fainting
- ☐ Emphysema/COPD
- ☐ Glaucoma
- ☐ Headaches
- ☐ High Cholesterol
- ☐ Hearing Problems
- ☐ Heart Disease
- ☐ Heart Murmur/Arrhythmia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Migraine
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Prostate Disease
- ☐ Seizures/Epilepsy
- ☐ Skin Disease: Chronic
- ☐ Skin Infections: Recurrent
- ☐ Sleep Disorder
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis or Positive Tes
- ☐ Ulcer Disease
- ☐ STD
- ☐ Other: _____
  _____
  _____
  _____

PAST SURGERIES

Check the box for any past surgeries

- ☐ None
- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Breast Surgery
- ☐ Bunion Surgery
- ☐ Cesarean
- ☐ Gallbladder (Cholecystectomy)
- ☐ Hysterectomy
- ☐ Tonsillectomy
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Other: _____
  _____
  _____

Name: _____ Date of Birth: _____ Date: _____

PRIOR TESTING (Dates and Results)

Bone Density: _____
Colonoscopy: _____
Stress Test: _____
Other: _____
_____
_____

List any other specialists you see:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

FOR WOMEN ONLY

Age periods began: _____
Date of last menstrual period: _____
Date of menopause: _____
Date of last pap smear: _____
Date of last mammogram: _____
Pregnancies:

- Total Number: _____
- Full Term: _____
- Premature: _____
- Miscarriages: _____
- Abortions: _____

FAMILY HISTORY

Relation	If Alive, Age	If Dead, Age at Death and Cause
Mother	_____	_____
Father	_____	_____
Brother/Sister	_____	_____
	_____	_____
	_____	_____
Spouse	_____	_____
Son(s)/Daughter(s)	_____	_____
	_____	_____
	_____	_____

PLEASE CHECK ANY CONDITION WHICH APPLIES TO A BLOOD RELATIVE

Condition	Who
☐ Alcoholism	_____
☐ Anxiety/Depression	_____
☐ Asthma	_____
☐ Bleeding Disorder	_____
☐ Cancer (type)	_____
☐ Diabetes	_____
☐ Heart Disease	_____
☐ High Blood Pressure	_____
☐ High Cholesterol	_____
☐ Kidney Disease	_____
☐ Migraines	_____
☐ Stroke	_____
☐ Thyroid Disease	_____
☐ Other:	_____

SOCIAL HISTORY

My current status is:
☐ Married ☐ Single ☐ Widowed
☐ Separated ☐ Divorced ☐ Other
With whom do you now live: _____
How would you describe your sexual orientation?:
☐ Heterosexual ☐ Homosexual ☐ Bisexual

	Y	N
Do you have a living will?	☐	☐
Are you an organ donor?	☐	☐
Are you exposed to hazardous conditions at work? Type:_____	☐	☐

Occupation: _____
Highest education level achieved: _____
Religious preference/beliefs: _____
Preferred language: _____

Race (select one):
☐ Black or African American
☐ Asian
☐ American Indian or Alaskan Native
☐ Other Race
☐ Hawaiian or Other Pacific Islander
☐ White

Ethnicity (select one):
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

PLEASE CHECK ANY THAT APPLY TO YOU

☐ Abdominal Pain
☐ Anxiety
☐ Change in Appetite
☐ Change in Mole
☐ Change in Weight
☐ Chest Pain/Pressure
☐ Incontinence
☐ Increased Urinary Frequency
☐ Joint Pain
☐ Leg Pain with Exercise
☐ Memory Concerns
☐ Muscle Aches

Name: _____ Date of Birth: _____ Date: _____

HEALTH HABITS

	Y	N
Do you drink alcohol?	☐	☐
• On average, how many drinks in 1 week? _____		
• Has anyone ever expressed concerns about your alcohol use? _____		
Do you smoke?	☐	☐
• What type? _____		
• How much? _____		
• When did you start? _____		
Have you quit smoking?	☐	☐
Do you use any other tobacco products?	☐	☐
Do you use recreational drugs?	☐	☐
Is your home a smoke free home?	☐	☐
Do you use sunscreen?	☐	☐
Are there any guns/weapons in your home?	☐	☐
Do you see the dentist regularly?	☐	☐

Date of last eye exam:_____
How often do you exercise?:_____
What type of exercise do you do?: _____
Do you follow a special diet?: _____

☐ Constipation	☐ Nasal Congestion
☐ Cough	☐ Nausea
☐ Depression	☐ Pain with Urination
☐ Diarrhea	☐ Palpitations
☐ Dizziness	☐ Rash
☐ Ear Pain	☐ Shortness of Breath
☐ Erectile Dysfunction	☐ Sore Throat
☐ Excessive Stress	☐ Vaginal Bleeding
☐ Fatigue	☐ Vaginal Discharge
☐ Fever	☐ Vomiting
☐ Headaches	☐ Vision Problems
☐ Hearing Problem	☐ Wheezing

IMMUNIZATION HISTORY

Immunization	Date of Last
Chickenpox disease or vaccine	_____
Hepatitis B disease or vaccine	_____
Influenza vaccine	_____
Pneumonia vaccine	_____
Rubella vaccine or test	_____
Tetanus vaccine	_____
Shingles vaccine	_____