State of Franklin HEALTHCARE ASSOCIATES™

Pinnacle Family Medicine
HEALTH HISTORY QUESTIONAIRE

Name _____ Date of Birth_____

Today's Date_____ Marital Status: Married Single Divorced Widowed

Emergency Contact and Number _____

Former Physician(s) including Specialists:_____

_____

Pharmacy: Local _____ **Mail**_____

Allergies _____

Significant Illnesses: past or chronic, such as hypertension, diabetes, heart disease, pneumonia, etc.

_____

_____

Surgeries: either the name of the surgery (such as vasectomy, hysterectomy, etc) or the site (such as tonsils, appendix, gallbladder, etc.)

_____

_____

Significant Injuries: broken bones, head injuries, back problems, etc.

_____

_____

Current Medications: include dosage and frequency, vitamins, minerals, herbs, etc. _____

_____

_____

Date of last Health Maintenance Items:

Complete Physical _____ Pap _____ Mammogram _____

Bone Density _____ Colonoscopy _____

Last Immunizations:

Tetanus booster _____ Pneumonia Vaccine _____ Flu Vaccine_____

Personal behaviors/habits: (circle and complete as appropriate)

Exercise No Yes _____

Diet No Yes _____

Sexual Activity No Yes Method of Birth Control _____\

Smoking No Yes Type _____ Began _____ Quit _____

Oral Tobacco No Yes Type _____ Began _____ Quit _____

Alcohol No Yes Type _____ Began _____ Quit _____

Recreational Drugs No Yes Type _____ Began _____ Quit _____

Family History:

	Mother	Father	Sisters			Brothers			Daughters			Sons		
Age														
Living? (Y/N)														
Cancer														
Diabetes														
Heart Disease														
Hypertension														
Stroke														
Alcohol Abuse														
Depression														
Mental Illness														
Seizures														
Other:														