Angela Willis MD
Family Practice

Original Date: _____/_____/_____
Dates Revised: _____/_____/_____

HEALTH HISTORY QUESTIONNAIRE

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

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

DOB _____/_____/_____

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

****Preferred Pharmacy:** _____

PERSONAL HEALTH HISTORY

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries:

Year	Reason	Hospital

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Name the Drug	Strength	Frequency Taken

Allergies to Medications:

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Alcohol:

Do you drink alcohol? ..... ☐ Yes ☐ No
How many drinks per week? _____
Are you concerned about the amount you drink? ..... ☐ Yes ☐ No

Tobacco:

Do you use tobacco? ..... ☐ Yes ☐ No
☐ Cigarettes - Pks/day_____ ☐ Chew - #/day _____ ☐ Pipe - #/day _____
☐ Cigars - #/day _____ ☐ # of Years _____ ☐
☐ Have you ever smoked? ☐ Yes ☐ No or **Year Quit** _____

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Drugs:

Do you currently use recreational or street drugs? ..... ☐ Yes ☐ No
Have you ever given yourself street drugs with a needle? ..... ☐ Yes ☐ No

FAMILY HEALTH HISTORY

	Age	Age at Death	Significant Health Problems or Cause of Death
Father			
Mother			
Brothers and Sisters	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		

	Age	Age at Death	Significant Health Problems or Cause of Death
Children	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
Grandparents (Mother's Side)			
Male			
Female			
Grandparents (Father's Side)			
Male			
Female			