MEDICAL ARTS ASSOCIATES, P.S.
HEALTH QUESTIONNAIRE

DATE_____

NAME:_____DOB_____
REASON FOR VISIT: _____
MEDICATIONS:_____

_____

_____

ALLERGIES: RX & OTHER_____
PAST MEDICAL HISTORY: ILLNESS, INJURIES, SURGERY, HOSPITALIZATION

_____

_____

_____

FAMILY MEDICAL HISTORY: INDICATE FAMILY MEMBER:

HYPERTENSION:_____
HYPERLIPIDEMIA:_____
HEART DISEASE (TYPE & AGE):_____
DIABETES, TYPE I OR II: _____
CHRONIC LUNG DISEASE OR ASTHMA (SPECIFY):_____
THYROID DISEASE: _____
BREAST CANCER: ?AGE_____
COLORECTAL CANCER: ?AGE_____
OTHER CANCER: _____
ALCOHOLISM: _____
DEPRESSION: ANXIETY: BIPOLAR (SPECIFY):_____
OTHER: _____

SOCIAL HISTORY:
MARITAL STATUS: SINGLE/MAR/DIV/SEP/WID/SIG OTHER/ENGAGED
CHILDREN: SON(S): DOB: _____DAUGTHER(S):DOB:_____
HOUSEHOLD MEMBERS: SEX/AGE/RELATION (OPTIONAL):_____

_____

WORK: STUDENT/HOMEMAKER/UNEMPLOYED/WORK PT/WORK FT/ SELF-EMP/RETIRED: TYPE OF WORK _____

NUTRITION: GOOD OR ?NEED IMPROVE: TYPE OF DIET: _____

EXERCISE: FREQUENCY/TYPE:_____

SEXUALLY ACTIVE: NO__YES__CONTRACEPTION_____

SMOKER: YES:_NO:_NEVER:_FORMER:_PACKS/DAY:__# YRS__YRS QUIT:___

ALCOHOL: NEVER:__OCC:__LIGHT:__MOD:__HEAVY:__ ETOH CONCERN?:__

RECREATIONAL DRUG(S): NO:__YES:__