Angela Willis MD
FAMILY PRACTICE

HEALTH HISTORY QUESTIONAIRRE

Today's Date: _____

PATIENT INFORMATION

Name: _____

Date of Birth: _____

Marital Status: □M □ S □ Divorced □ Widowed □Separated

Gender: □M □F □ Other

PHARMACY INFORMATION

Pharmacy: _____

LIST ALL OF YOUR MEDICAL PROBLEMS:

_____
_____
_____
_____
_____
_____
_____

LIST ALL OF YOUR SURGERIES :

_____
_____
_____
_____

LIST ALL OF YOUR ALLERGIES (MEDICATIONS, FOODS, LATEX, ETC)

_____
_____
_____
_____
_____

LIST ALL OF YOUR MEDICATIONS (EVEN FROM OTHER DOCTORS) - Use back if needed

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

HEALTH HABITS

Do You Smoke: **Yes** **No** ***How many packs per day:*** _____
How many years: _____

Have you ever smoked: **Yes** **No**
If so, when did you quit: _____

_____

Do you use other forms of Tobacco: **Yes** **No** ***How many per day:*** _____
(Chew, Pipe, Cigar, Vape, E-Cig, etc) ***How many years:*** _____

_____

Do You Drink Alcohol: **Yes** **No** **How Much:** ***Occasional***
<5 drinks/week
5-10 drinks/week
>10 drinks per week

_____

Do You Use Recreational or Illicit Drugs: **Yes** **No** **Type:** ***Marjiuana***
(not prescribed by your doctor) ***Narcotics***
Cocaine/Heroin
Other

FAMILY HISTORY

Medical Problems Other Family Members Have Had:

Father _____
Mother _____
Siblings _____
Grandparents _____
_____

PREVENTIVE CARE HISTORY

	DATE:			
LAST PAP	_____	**NORMAL**	or	**ABNORMAL**
LAST MAMMOGRAM	_____	**NORMAL**		**ABNORMAL**
LAST COLONOSCOPY	_____	**NORMAL**		**ABNORMAL**
LAST PROSTATE EXAM	_____	**NORMAL**		**ABNORMAL**
LAST BONE DENSITY	_____	**NORMAL**		**ABNORMAL**