Quest

COMMUNITY HEALTH PARTNERS
REAL PEOPLE. REMARKABLE HEALTHCARE.

Patient Label
Name: _____
DOB: _____
M#:_____

Health History Questionnaire

Patient Name:_____ Date of Birth:_____

Primary Care Provider:_____

Dentist:_____Last dental visit:_____
Eye Doctor:_____ Last eye exam:_____

Do you see any specialist providers: Y or N

If so, please list:_____

Preferred Pharmacy:

1st Choice:_____ 2nd Choice:_____

List all medications, vitamins, and over the counter medications, you are taking.

Medication	Dose	How often you take it

Please list any allergies and reaction:

Allergy	Reaction

Patient Histories:

Are you employed? Y or N Occupation:_____

Please circle answers to the questions below			
Marital status Married Partner Divorced Widowed Single	**Do you have any children?** # Boys:_____ # Girls:_____	**Do you use tobacco?** Y or N	**Do you drink alcohol?** Y or N
How far did you take your education?			
G.E.D.	Diploma	Some college	College Degree:_____

Please Fill Out Back Page

Patient Medical/Surgical History: please list all past medical history and what year it occurred.

Medical Diagnosis	**Year**	**Comments**
Surgery	**Year**	**Comments**
	Pregnancies	
# of Live Births	# of abortions	# of miscarriages

Do you have a history of (circle all that apply)?

Alcohol Abuse Drug Abuse IV Drug Use Incarceration

Do you have a history of physical/sexual/verbal abuse? Y or N

Are you sexually active?	Yes	No

What is your birth control method?

Condom Pill IUD Other None Post-Menopausal

Family History:

	Alive and well	alchoholism	asthma/copd	blood clots	breast cancer	colon cancer	depression	diabetes	drug abuse	heart attack	high cholesterol	high blood pressure	mental illness	prostate cancer	stroke	other
mother																
father																
sister																
brother																
son																
daughter																
aunt																
uncle																
grandmother																
grandfather																

Additional Family History:_____

Thank you for taking the time to complete this form.