Greensboro Medical Associates, PA

HEALTH INFORMATION QUESTIONNAIRE

NAME ______________________________________ AGE _______ D.O.B. __________
LAST, FIRST MIDDLE

PLACE OF BIRTH ____________________ PRIMARY CARE M.D. __________________

OTHER DOCTORS YOU SEE ____

MARITAL STATUS (circle one) Single Married Separated Divorced Widowed

EMPLOYMENT STATUS Full-Time Part-Time Not Employed Retired Student

EMPLOYER ______________________________OCCUPATION _____________________

HOW WERE YOU REFERRED TO US ____

MAIN REASON FOR VISIT ____

EDUCATION (years) _____ RELIGION ____________ MILITARY SERVICE ____________

REGULAR EXERCISE (type) ______________ (circle) none light moderate strenuous

HOBBIES/SPORTS ____

SPECIAL DIET __YES __NO WHAT TYPE? _____________________________

HABITS-- Have you used IV drugs?___ marijuana?___ narcotics?___ etc.?_______

Tobacco-- Type?________________ How much?___________ Quit?__________

Caffeine – (cups per day) Coffee:_______ Tea:_______ Cola:________

Alcohol-- Type?__________ How much?_________ Days per week______Quit?__________

History of Blood Transfusions Yes No AIDS Blood Test Yes No

Sexual Orientation (circle) Heterosexual Homosexual Other

MEDICATIONS (List all medications, eye drops, vitamins, including over-the-counter medications and supplements – include dose and frequency)

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

DRUG OR FOOD Allergies + Reaction :____

PREVIOUS SURGERIES :

OPERATIONS	DATE	HOSPITAL	SURGEON

PREVIOUS INJURIES ____

PREVIOUS HOSPITAL STAYS ____

IN CASE OF EMERGENCY, CONTACT :____

ADDRESS (of above) ____

PHONE (of above) home________________ **cell**____________________ **work**__________________

Living Will? Yes No **DNR ORDER? Yes No** **Advance Directives? Yes No**

FAMILY MEDICAL HISTORY

RELATIVE	AGE	MEDICAL CONDITIONS	AGE and CAUSE OF DEATH
Mother			
Father			
Sisters			
Brothers			
Daughters			
Sons			

Any other medical conditions, such as diabetes, cancer, melanoma, aneurysm, heart disease or stroke in relatives?____

YOUR HEALTH (please circle):

Your general health:	**Good**	**Fair**	**Poor**
Your sleep quality:	**Good**	**Fair**	**Poor**
Your energy level:	**Good**	**Fair**	**Poor**

Have you had? **(Please answer the following questions)**

Last Colonoscopy _________________
Last Mammogram _________________
Last Eye Exam ___________________
Last Pap Smear ___________________
Last Bone Density _________________

Last Tetanus Vaccine ________________
Last Pneumonia Vaccine _____________
Last Aortic Aneurysm Screen _________
Last Hepatitis B Vaccine ______________

I certify that the information I have given above is correct to the best of my knowledge.

____ __________ ___________________________

Patient's Signature **Date** **mobile #**

____ ________________

Signature and relationship of person filling out form **Date**