Sweetwater Medical Associates
History Questionnaire

Name: _____ DOB: _____/_____/_____ Date: _____/_____/_____

CURRENT MEDICATIONS: LIST ALL MEDICATIONS YOU ARE TAKING, BOTH PRESCRIPTION AND NON-PRESCRIPTION. INDICATE STRENGTH AND NUMBER OF PILLS A DAY.

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

LIST ANY ALLERGIES TO MEDICATIONS: INCLUDE THE EFFECTS THE MEDICATIONS MAY HAVE.
_____

PAST MEDICAL HISTORY: LIST ANY CHRONIC MEDICAL PROBLEMS YOU MAY HAVE, i.e. ALLERGIES, ASTHMA, DIABETES, HIGH BLODD PRESSURE, HEART ATTACK, LIVER OR KIDNEY PROBLEMS, etc….
_____
_____
_____

PAST SURGICAL HISTORY: LIST ALL PRIOR SURGERIES AND YOUR AGE WHEN THEY OCCURRED.
_____
_____

WHEN WAS YOUR LST COLONOSCOPY? _____ BONE DENSITY SCAN? _____
WHEN WAS YOUR LAST PAP SMEAR? _____ WHEN WAS YOUR LAST MAMMOGRAM? _____
HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR? □YES □NO MAMMOGRAM? □YES □NO
HAVE YOU EVER HAD A BLOOD TRANSFUSION? □YES □NO

IMMUNIZATIONS: WHEN WAS YOUR LAST TETNUS SHOT? _____ PNEUMONIA SHOT? _____

SOCIAL HISTORY:
DO YOU SMOKE? □YES □NO HOW MANY PACKS PER DAY? _____ WHEN DID YOU START? _____
PAST HISTORY OF SMOKING: WHEN DID YOU START? _____ WHEN DID YOU QUIT? _____
DO YOU DRINK ALCOHOL? □YES □NO WHAT TYPE? _____ NUMBER PER DAY? _____
DO YOU USE ILLEGAL DRUGS? □YES □NO WHAT TYPE? _____
HAVE YOU EVER USED A NEEDLE TO ADMINISTER ANY ILLEGAL DRUG? □YES □NO
DO YOU HAVE A TATOO? □YES □NO
WHAT IS YOUR OCCUPATION? _____
DO YOU EXERCISE? □YES □NO HOW OFTEN? _____ HOW LONG? _____
DO YOU WEAR YOUR SEAT BELTS? □YES □NO

FAMILY HISTORY: DO ANY FAMILY MEMBERS HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?

HIGH BLOOD PRESSURE	FAMILY MEMBER: _____
CANCER (INCLUDE TYPE)	FAMILY MEMBER: _____
DIABETES	FAMILY MEMBER: _____
HEART ATTACK/DISEASE	FAMILY MEMBER: _____
STROKE	FAMILY MEMBER: _____
ASTHMA/ALLERGIES	FAMILY MEMBER: _____
OTHER	FAMILY MEMBER: _____