Western Missouri Family Healthcare History Questionnaire

Please take the time to fill out this questionnaire carefully. If you have any questions, ask for assistance. If you have concerns that are not listed, make note of them at the bottom of the page. The completed form will greatly assist us in providing a thorough evaluation.

Confidential Patient Profile

Name: ____ Date of Birth: ___________________ Nickname:___________

Marital Status: S/M/D/W/LP Spouse Name:(if applicable) ____

Occupation:_________________________________ Who Referred you?_____________________________________

Children (Names & Ages Please)____

Previous Doctor:_____________________________City____________________State if not Missouri______________

Other Doctors and/or Specialist You see____

Past Medical History: In this section please check the appropriate box that applies to you.

Illness	Now	Past	Year/Age	Illness	Now	Past	Year/Age
ADD/ADHD				Heart Murmur			
Alcohol/Drug Abuse				Hepatitis B or C			
Anemia				High Blood Pressure			
Anxiety/Depression				HIV/AIDS			
Arthritis				Irritable/Inflammatory Bowel			
Asthma/Bronchitis				Kidney Disease			
Blood Disorders				Liver Disease/Hep A			
Bowel Disorder				Obesity			
Cancer				Pneumonia			
Cardiac Arrhythmias				Polycystic Ovarian Syndrome			
COPD/Emphysema				Prostate Issues			
Diabetes Type I or Type II				Rheumatoid Arthritis			
Fibromyalgia				Seasonal Allergies			
Gastric Reflux/GERD				Seizures/Epilepsy			
Gastric/Intestinal Ulcers				Sleep Apnea			
Genital Infections				Stroke			
Headaches/Migraines				Thyroid Disorders			
Heart Attack/Coronary Artery Disease				Other:			

Preventative Health History:

ALL PATIENTS	Female Patients	Male Patients
When was your last tetanus shot?	When was your last pap smear?	When was your last PSA test?
Have you ever had a colonoscopy Y/N If so, when?	Have you had an abnormal pap? When?	When was your last Prostate exam?
Have yoe ever had a pneumonia vaccine? Y/N	When was your last mammogram?	

If so, when?		
Are you interested in getting the FLU vaccine (Oct – Mar only)?		

Social History: In this section please check the appropriate box that applies to you.

Do you use tobacco? Smoke or Chewing Tobacco?	Yes	No	Past	If Yes, How Much do you Smoke/Chew a Day?	How long have you been smoking? Or age you started.
Do you drink Alcohol of any kind?	Yes	No	Past	If Yes, How often?	If Yes, What kind?
Do you exercise?	Yes	No	Past	If Yes, How often?	If Yes, What kind?
Do you do drugs or illegal substances?	Yes	No	Past	If Yes, How often?	If Yes, What kind?

Family History: In this section please fill in the health history of your family members. Significant medical problems may include: auto immune conditions (lupus, rheumatoid arthritis) Cancer, Psychiatric conditions-depression, anxiety, bipolar; thyroid conditions, heart disease, diabetes, high blood pressure/hyper or hypotension; kidney disease, blood or clotting disorders.

Relative	**Age**	**Age at Death (if applies)**	**Health issues/Cause of Death**
Father			
Mother			
Sibling			
Sibling			
Sibling			

Hospitalizations and Surgical History: Include reason and year.

Surgery/Hospitalization	**Year or Age**	**Reason for Surgery/Hospitalization**

MEDICATION ALLERGIES: List name of all allergies and reaction-If Seasonal Allergies, just write Season Allergies and Symptoms

Medications	**Reaction**
1.	

2.	
3.	
4.	
6.	

Current Medications List: Please list all pharmaceutical medications and dosage that you are currently taking. If you need more room, please ask receptionist for additional list. (Please include allergy medications and medications you just use as needed)

Medication	Dosage	How Often
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Over the Counter/Herbs/Supplement List: Include all homeopathic, herbs, vitamins, minerals or over the counter medications that you are taking. (Please include allergy medications and medications you just use as needed)

Supplement	Dosage	How Often
1.		
2.		
3.		
4.		
5.		

Pharmacy Preference: City, & Phone Number- If you use a mail in pharmacy please include your policy number here so when we send in RX it will go through faster

Name:________________________________**City:**________________________**Phone #**________________________

If mail in Pharmacy- Pharmacy Fax #_____________________________**ID #**_________________________________

Please inform us if you have a religious belief that would prohibit us from performing a certain medical treatment (such as blood transfusions).Treatment(s) to be excluded: ____

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

______________________________ ______________________
Signature Date

Additional Medication Sheet: Please list all pharmaceutical medications and dosage that you are currently taking.

Medication	Dosage	How Often
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		

Current Supplement List: Include all homeopathic, herbs, vitamins, minerals or over the counter medications that you are taking. (Please include allergy medications and medications you just use as needed)

Supplement	Dosage	How Often
1.		
2.		
3.		
4.		
5.		