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| |  | | --- | | **HEALTH HISTORY QUESTIONNAIRE** | |
| |  | | --- | | Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL. PLEASE COMPLETE USING BLACK INK. | |
|  |
| |  | | --- | | Main reason for today's visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Other concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current Height and Weight:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
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| |  |  | | --- | --- | | |  | | --- | | **ALLERGIES** | | |  | | |  | | --- | | **List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.** | | | |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  | | --- | | ALLERGY | | 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | | --- | | REACTION | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | | | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | |  | | --- | |  | | **PHARMACY**  LOCAL PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  MAIL ORDER PHARMACY (IF APPLICABLE): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **MEDICATIONS**  **Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers** | | |  | | --- | |  | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  | | --- | | DRUG NAME | | 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 7.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 8.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | | --- | | STRENGTH | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | | --- | | FREQUENCY TAKEN | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  | | |  | | --- | |  | | | |

**PAST SURGICAL HISTORY**

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| |  | | --- | | **IMMUNIZATION HISTORY** | |
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| |  | | --- | | **PAST MEDICAL HISTORY** | |
| **Please circle ALL that apply:** |
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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| |  | | --- | | **(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY** | |
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| Have you EVER had an abnormal PAP or Mammogram? *Please specify and provide dates:*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| |  | | --- | | **FAMILY HEALTH HISTORY** | |
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| |  |  |  |  | | --- | --- | --- | --- | | **RELATION** | **ALIVE?** | **AGE** | **SIGNIFICANT HEALTH PROBLEMS** | | **Grandmother** (maternal) | Y/N | \_\_\_\_\_\_ | Alcoholism     Arthritis     Depression     Cancer     Diabetes     Genetic disease | |  | Heart disease       Hypertension       Osteoporosis       Stroke | | **Grandfather**  (maternal) | Y/N | \_\_\_\_\_\_ | Alcoholism     Arthritis     Depression     Cancer     Diabetes     Genetic disease | |  | Heart disease       Hypertension       Osteoporosis       Stroke | | **Grandmother** (paternal) | Y/N | \_\_\_\_\_\_ | Alcoholism     Arthritis     Depression     Cancer     Diabetes     Genetic disease | |  | Heart disease       Hypertension       Osteoporosis       Stroke | | **Grandfather**  (paternal) | Y/N | \_\_\_\_\_\_ | Alcoholism     Arthritis     Depression     Cancer     Diabetes     Genetic disease | |  | Heart disease       Hypertension       Osteoporosis       Stroke | | **Father** | Y/N | \_\_\_\_\_\_ | Alcoholism     Arthritis     Depression     Cancer     Diabetes     Genetic disease | |  |  |  | Heart disease       Hypertension       Osteoporosis       Stroke | | **Mother** | Y/N | \_\_\_\_\_\_ | Alcoholism     Arthritis     Depression     Cancer     Diabetes     Genetic disease | |  |  |  | Heart disease       Hypertension       Osteoporosis       Stroke | | **Brother/Sister** | Y/N | \_\_\_\_\_\_ | Alcoholism     Arthritis     Depression     Cancer     Diabetes     Genetic disease | |  |  |  | Heart disease       Hypertension       Osteoporosis       Stroke | | **Brother/Sister** | Y/N | \_\_\_\_\_\_ | Alcoholism     Arthritis     Depression     Cancer     Diabetes     Genetic disease | |  |  |  | Heart disease       Hypertension       Osteoporosis       Stroke | | **Other:\_\_\_\_\_\_** | Y/N | \_\_\_\_\_\_ | Alcoholism     Arthritis     Depression     Cancer     Diabetes     Genetic disease | |  |  |  | Heart disease       Hypertension       Osteoporosis       Stroke | |

Please list any other Physicians or Medical Specialists that you currently use, as well as the medical issues they are managing for you:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have ever had any of the following, please note the dates and results, if possible:

Colonoscopy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DEXA/Bone Density Scan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note any test, with dates and results, you may have had in the past that you feel are currently relevant, including X-rays, MRI/A, CT, Ultrasounds, Nuclear medicine Scans, Biopsies, Endoscopy, Cystoscopy, Colposcopy, Stress Tests, Sleep Studies, Cardiac Catheterizations, etc.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| |  |  | | --- | --- | | |  | | --- | | **SOCIAL HISTORY** | | |  | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  |  | | --- | --- | --- | | |  | | --- | | **Education**  Less than 8th grade  High school  2 year college  4 year college  Post graduate  **Marital Status**  Married  Single  Divorced  Separated  Widowed  Domestic Partner | | **Exercise Level**  None  Occasional  Moderate  High | | |  | | |  | | --- | |  | | | **Name:**  **DOB:**  **Age:**  **Address:**  **Phone Number:**  **Insurance Provider & Member ID:** | | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | |  |  | | --- | --- | | **Caffeine**  None  Occasional  Moderate  Heavy  # of cups/cans per day \_\_\_\_\_  **Alcohol**  Do you drink alcohol? Y/N  If so, how often?  Occasionally  < 3 times/week  >3 times/week  Drinks per week \_\_\_\_ |  | |  |  | |  | | |  | |  | | |  |  |  | | --- | --- | --- | | |  |  | | --- | --- | |  | **Tobacco**  Current smoker? Y/N  Cigarettes: \_\_\_\_ pks./day  Chew: ­­­\_\_\_\_ /day  Cigars: \_\_\_\_/day  # of years: \_\_\_\_\_\_  Former smoker? Y/N  Year quit \_\_\_\_\_ | | |  |   **Drugs**  Do you use recreational or street drugs? Y/N  If yes, list:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Anyone currently using marijuana for any reason will not be accepted as a new patient.)  Have you used recreational or street drugs in the past? Y/N  If yes, list:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |
|  |  |

**Occupation:**

**Religious Affiliation:**

**Interests/Hobbies:**

**Do we see any other family members?**

**Name and ages of children, if any:**

**Please add any other information about your health that you would like your provider to know here:**

**Were you referred by someone? If so, whom can we thank for the referral?**

**Are you coming to Dr. Hippeard for controlled substances, such as Xanax, Ativan, Valium, Klonopin, Adderal, Ritalin, Concerta, Vyvanse, Hydrocodone, or Oxycodone? Please note that Dr. Hippeard will NOT prescribe these medications .**

**Are you coming to Dr. Hippeard for work related issues/concerns? Please describe.**

**Are you coming to Dr. Hippeard for concerns related to COVID or the COVID vaccination? Please note that Dr. Hippeard will NOT prescribe Ivermectin or issue medical documentation exempting you from employer requirements to take the COVID vaccine.**

**Are you currently under the care of any other providers or specialists? If yes, please provide their names and specialty.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient, Guardian, or Caregiver Signature Date