Family Health Services of Erie County
An Independent Healthcare Provider

FAMILY HEALTH SERVICES OF ERIE COUNTY

Health Questionnaire

General Information

Name: _____ Sex: M F (circle one)

Address: _____ Date of Birth: _____

_____ SSN: _____ - _____ - _____

Home Phone: _____ Preferred Pharmacy:

Employer: _____ _____

Highest Level of Education (circle one)

School (highest grade): College:

1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4

Post-graduate Degree: _____

Marital Status: (circle one)

Single Married Widowed Separated Divorced

If Applicable

Spouse's Name: _____ Date of Birth: _____

Spouse's Address: _____

Contact in case of Emergency: Relation: _____

_____ Telephone: _____

Date of last doctor's visit: _____

Who were you referred by? _____

Previous Physician: _____

Who are other Physicians you are currently seeing? _____

_____

_____

_____

Are you allergic to any medications? If so, what are they? _____

_____

What Medication are you currently taking? _____

_____

_____

_____

_____

Major Medical Problems: briefly describe what medical problems you are seeking attention for:

_____

_____

_____

Past Medical History: (please circle any that you may have had)

Angina / Heart Pain	Heart Attack	High Blood Pressure
Irregular Heart Beat	Asthma	Emphysema
Chronic Bronchitis	Pneumonia	COPD
Tuberculosis	Diabetes (sugar)	Thyroid Problems
Colitis / Bowel Trouble	Gallstones	Stomach Ulcers
Hepatitis	Liver Disease	Drinking Problems
Alcoholism	Blood Clots	Pulmonary Embolism
Sickle Cell Disease	Anemia	Blood Problems
Kidney Disease	Kidney Stones	Prostate Problems
Urine Infections	Migraines / Headaches	Epilepsy / Seizures

Stroke	Alzheimer's Disease	Nerves / Anxiety
Depression	Mental Illness	Cataracts
Glaucoma	Arthritis / Rheumatism	Psoriasis
Rash	Cancer	Other: _____

Surgical History: (please list dates you have been in the hospital and what for)

Appendix	Gallbladder	Tonsils
Breast	Hysterectomy	Hernia
Colon / Intestines	Heart	Hemorrhoids

Hospitalizations: (please list dates you have been in the hospital and what for)

_____

_____

_____

Trauma: (please list any major traumas or accidents, such as a car accident, severe fall, etc.)

_____

_____

_____

_____

Family History: (please circle any that someone in your family has had)

High Blood Pressure	Diabetes (Sugar)	Alcoholism
Asthma	Kidney Problems	Mental Illness
Colitis	Tuberculosis	Anemia
Stroke	Migraines	Bleeding Problems

Cancer (what kind): Lung Colon Breast Ovary Prostate Other: _____

Heart Attack: who had one, and what age were they?

_____

Other: _____

Obstetrical/Gynecological History:

Pregnancies:

Total Number: _____ Live Births: _____ Miscarriages / Abortions: _____

Deliveries:_____ Vaginal: _____ C-Section: _____

Menstruation:

When was the first day of your last menstrual cycle? _____

How many days does your period usually last? _____

How many days apart? _____

Have you ever had an abnormal Pap smear? Yes No (circle one)

If so, what was done? _____

Sexual History:

Are you currently sexually active? yes no

Did you or your partner use any form of contraception to protect yourselves from pregnancy or sexually transmitted diseases?

yes no

What types of contraceptives do you use? (please circle any that you use)

Condoms Diaphragm Foam / gel Sponges IUD Oral contraceptives (the pill)

Implants (Norplant) Shot (Depo-Provera) Rhythm / NFP None Other: _____

Have you or your partner had a tubal ligation or a vasectomy? yes no

Have you ever had a sexually transmitted disease? (circle any) yes no

Gonorrhea Chlamydia Herpes Trichomoniasis Syphilis

Pelvic Inflammatory Disease (PID) HIV Genital Warts Other: _____

Have you ever been tested for HIV or AIDS? yes no

Would you like to be tested for HIV or AIDS? yes no

General Health Questions: (circle or answer the appropriate question)

Have you ever smoked? yes no If yes, how many packs each day? _____

Do you smoke now? yes no If yes, how many packs each day? _____

Have you ever tried to quit? yes no

How many years have you smoked? _____

Do you drink alcohol? yes no

Have you ever been concerned about your drinking? yes no

Have you ever tried cutting down on your drinking? yes no

Do you get annoyed when others comment on your drinking? yes no

Do you ever have a drink first thing in the morning? yes no

Have you ever felt shaky when not drinking? yes no

Have you ever had blackouts, seizures, or DT's? yes no

Have you ever been in a drug or alcohol treatment program? yes no

Do you or have you ever used recreational drugs (marijuana, cocaine,

Heroin, LSD, PCR, or any others? yes no

Have you ever used drugs intravenously (into the vein)? yes no

Have you ever shared needles? yes no

Have you ever tried to stop using drugs? yes no

Do you drink beverages with caffeine (coffee, tea, cola)? yes no

If yes, how many cups per day? _____

Have you been exposed to any chemicals, toxins, poisons, fumes, smoke,

Asbestos, or radioactive material at home or at work? yes no

Have you traveled outside of the U.S. in the past year? yes no

If yes, where have you gone? _____

Preventive Medicine:

Please list the date and result if known, of the most recent test, exam, vaccination or immunization.

Cholesterol: _____

EKG / Stress test: _____

Sigmoidoscopy / Colonoscopy: _____

Stool for occult blood Cards: _____

Dental Exam: _____

Eye Exam:_____

Influenza (flu shot) or pneumonia vaccine:_____

Hepatitis B vaccine_____

Have you ever had a blood transfusion? yes no

Do you exercise regularly? yes no

Do you wear seatbelts? yes no

Do you follow a special diet? yes no

for Men: Do you perform monthly testicular self-exams? yes no

Have you had your prostate checked before? yes no

for Women: Date of last Pap Smear:_____

Date of last mammogram:_____

Do you know how to do monthly self breast exams? yes no

Do you do monthly self breast exams? yes no