Huntington
Health Physicians

HEALTH ASSESSMENT QUESTIONNAIRE

Patient Name: ____ Today's Date:____/_____/______

Date of Birth: ___/___/_____ Age:____ Gender: Male ☐ Female ☐ Marital Status: Married☐ Single☐ Divorced☐ Widow☐

Reason for your visit today

Past Medical History			
Problem	**Year**	**Problem**	**Year**

Surgeries & Hospitalization *(Hospitalized for any surgical operation or serious illness)*		
Month / Year	**Reason**	**Hospital**

Allergies or Intolerances to Medication or Food *List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)*			
Medication / Food	**Reaction**	**Medication / Food**	**Reaction**

Medications, Vitamins and Herbal Supplements *Prescribed drugs and over-the-counter drug e.g. vitamins, inhaler* ☐ *Check if using other sheet for medications*			
Medication Name	**Strength**	**Frequency Taken**	**Reason for use**

Family Health History						
Relative	**Age**	**Significant Health Problems**	**Relative**		**Age**	**Significant Health Problems**
Father:			Children:	☐M☐ F		
Mother:				☐M☐ F		
Brother(s)/ Sister(s):				☐M☐ F		
				☐M☐ F		
			Other:			
			Other:			

Immunization History *Please list below the most recent dates of your vaccines*					
Tetanus booster (Tdap)	☐ NO ☐ YES	Date:________	Influenza/Flu	☐ NO ☐ YES	Date:________
Pneumonia (Pneumovax)	☐ NO ☐ YES	Date:________	Shingles (Zostavax)	☐ NO ☐ YES	Date:________
Other:________________	Date:_____	Other:_____________	Date:______	Other:__________	Date:________

Health Maintenance Screening *Please list below the most recent dates of your health screening tests*					
Test	***Month/Year***	***Result***	***Test***	***Month/Year***	***Result***
Mammogram		☐ Normal ☐Abnormal	Colonoscopy /Stool Test		☐ Normal ☐Abnormal
Pap Smear		☐ Normal ☐Abnormal	Prostate/PSA		☐ Normal ☐Abnormal
Last Menstrual Period Date:____/_____/_____					

Social History		
Occupation: ______________________________ Current Employment:_______________________		
Do you have children? ☐ NO ☐ YES How many?_________________ Female(s) ____________ Male(s) ____________		
Tobacco smoke or chew tobacco?	☐ NO ☐ YES	# packs per day___ Former Smoker # years smoked ____ Quit Date:____
Do you drink alcohol?	☐ NO ☐ YES	Type:_____ How often:____ # of drinks per day ___
Do you currently use recreational drugs?	☐ NO ☐ YES	Type: _____ How Often: _____What kind?
Do you consume caffeine?	☐ NO ☐ YES	Type:_____ # of drinks per day ______
Do you exercise 3 or more days a week?	☐ NO ☐ YES	Type:_____

Specialty Services Are you currently seeing any other doctors?			
Doctor Name	**Type of Doctor**	**Last Seen**	**Problem**

Medical Forms

Please check any of the following forms you have completed:

- ☐ Advance Directive for Health Care
- ☐ Durable Power of Attorney (DPA) for healthcare decisions
- ☐ Living Will
- ☐ POLST (Physician Orders for Life Sustaining Therapy)
- ☐ Know about these or have the forms but have not completed them
- ☐ Don’t know what these are

Anything else we should know?

Thank You for taking the time to complete this form.