BROOMFIELD FAMILY PRACTICE

BROOMFIELD FAMILY PRACTICE HEALTH HISTORY QUESTIONNAIRE: 18 +

Legal Name: ______________________________________ Date of Birth: ______________________________
Daytime Phone: ____________________________________ Evening Phone: _____________________________
Address: ____
____
Email: ____
Nickname/Preferred Name: ____
Emergency Contact: _________________________________ Phone Number: ______________________________
Race: ____________________ Ethnic Background: _____________________ Language: ______________________

HEALTH HISTORY:

1. Have you been hospitalized, other than childbirth, at least overnight for any reason? ___ No ___ Yes, date(s) and reason: _
____
____
____

2. Have you had any surgery? ___No ___ Yes, date(s) and reason: ______________________________________
____
____
____

3. Please list your medications, including prescriptions, vitamins, over-the-counter medications and herbal supplements: ___
____
____
____
____

4. Do you have any chronic medical conditions or significant medical conditions? ___ No ___ Yes, please explain: ________
____
____
____
____

5. Have you had a colonoscopy, upper endoscopy, treadmill test or other special diagnostic tests? ___ No ___ Yes, please list date and type: ____
____
____
____

6. Do you have allergies or reactions to any medications? ___ No ___ Yes, please explain: ______________________
____
____
____

SOCIAL HISTORY:

1. Do you have any advanced directives, such as a living will or durable power of attorney? ___ No ___ Yes, please check: ___Living will durable ___ Medical power of attorney ___ Do not resuscitate
2. What is your occupation? ____
3. Marital Status (choose one):___ single ___married ___widowed ___ divorced ___cohabitate. Spouse or partner's name: __
____
4. Do you have any children? ___ No ___ Yes: # of son's ___ # of daughter's___

5. Do you smoke or chew tobacco? _____ No ___ Former: ___________
Type_________________________ Frequency ________________ _____________________________ Years______
Current: Type_______________________ Frequency ______ Years ___
6. Do you drink caffeine? ___ No ___ Yes: Type______________________ Frequency ______________________________
7. Do you get any regular exercise outside of work? ___ No ___Yes: Type: ____
Frequency ____
8. Do you drink alcoholic beverages? ____ No ____Yes: Type: ____
Frequency ____
9. Do you use any recreational drugs such as marijuana, cocaine, etc.? ___ No ___Yes: Type: _______________________
Frequency: ____

FAMILY HISTORY:

1. Do any members of your family have any history of the following?

	None	Father	Mother	Sister(s)	Brother(s)
Alzheimer's					
Asthma					
Alcoholism					
Coronary Artery Disease					
Cancer					
History of Stroke					
Depression					
Diabetes					
High Blood Pressure					
High Cholesterol					
Mental Illness					
Migraines					
Kidney Disease					
Seizure Disorder					

2. Are there any other significant conditions in your family that your health care provider should know about? ___ No
Yes, please explain: ____
____
____
____

Would you like to use *SECURE* Healthcare Email to communicate with your provider?
No ____ Yes, email address ____

____ ____________________
Signature (patient or parent/guardian if patient is under 18) Date