Alyeska Family Medicine

State of the Art Care, Traditional Values

Health History Questionnaire

Welcome to Alyeska Family Medicine. In order to provide you the highest quality medical care we need to know as much as possible about your medical history. Please be as detailed as possible. If you have any questions any staff member will be happy to assist you. Thank you very much for your attention and patience in completing this form.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**

If you have any Allergies or Bad Side Effects to Medications, please list below:	
Medication	Reaction
1.	
2.	
3.	

Please list ALL Medications, Vitamins and Herbal Supplements						
Medication	Strength	Frequency		Medication	Strength	Frequency

Personal Medical History			
Allergy/Dermatology	**Gastrointestinal**	**Neurologic/Genetic**	**Renal/Genitourinary**
❑ Eczema	❑ Acid Reflux (GERD)	❑ ADD/ADHD	❑ Endometriosis
❑ Allergies	❑ Cirrhosis of the Liver	❑ Alzheimer's Disease	❑ Erectile Dysfunction
❑ Psoriasis	❑ Colon Polyps	❑ CVA/Stroke	❑ Kidney Failure
❑ Seborrheic Dermatitis	❑ Crohn's Disease/Ulcerative Colitis	❑ Dementia	❑ Kidney Stones
Cardiovascular	❑ Diverticulitis	❑ Mental Retardation	❑ Recurrent UTI
❑ Abnormal Heart Rhythm	❑ Gall Stones	❑ Migraine	❑ Prostate Enlargement (BPH)
❑ Abnormal Heart Valve	❑ Hepatitis	❑ MS	❑ Urinary Incontinence
❑ Blood Clots in Legs	❑ Irritable Bowel Syndrome	❑ Parkinson's Disease	**Mental Health**
❑ Blockage of Carotid Artery	❑ Ulcers	❑ Seizures	❑ Anxiety
❑ Blockage of Coronary Artery	**Hematologic**	❑ Tension Headaches	❑ Bipolar
❑ Congestive Heart Failure (CHF)	❑ Anemia (Low Blood Count)	❑ TIA	❑ Depression
❑ Heart Attack	❑ Bleeding Problems	❑ Headaches	❑ Insomnia
❑ High Blood Pressure	❑ Sickle Cell Disease	**Pulmonary**	❑ OCD
❑ High Cholesterol/Triglycerides	**Musculoskeletal**	❑ Asthma	❑ Schizophrenia
Endocrine	❑ Chronic Pain	❑ Blood Clot in the Lung	**Infectious Disease**
❑ Diabetes Type I	❑ Fibromyalgia	❑ Cystic Fibrosis	❑ Herpes (Cold Sores)
❑ Diabetes Type II	❑ Gout	❑ Emphysema	❑ Herpes (Genital)
❑ Pre-Diabetes	❑ Osteopenia	❑ Pneumonia (more than once)	❑ HIV/AIDS
❑ Hyperthyroidism	❑ Osteoporosis	❑ Sarcoidosis	❑ Syphilis
❑ Hypothyroidism	❑ Rheumatoid Arthritis	❑ Sleep Apnea	
		❑ Tuberculosis	
Other Medical Conditions Not Listed:			

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Women's Health			
Number of:	Pregnancies:	Live Births:	Miscarriages/Abortions:
Have you experienced menopause or had a hysterectomy? ❑ Yes ❑ No			

If you have had any form of cancer including skin cancers please list below:		
Type of Cancer	*Year of Diagnosis*	*Current Status*

Medical Care
List other providers participating in your medical care:
Have you been seen at an urgent care facility or emergency department recently? ❑ Yes ❑ No If yes, where:
Organ Donor: ❑ Yes ❑ No Living Will: ❑ Yes ❑ No Advance Directives (If yes, please provide copy): ❑ Yes ❑ No

Surgical History		
Type of Surgery	Year	Surgeon

Family Medical History

(Medical conditions which apply to your immediate family Parent, Sibling, Child, do not include uncles, cousins, grandparents, etc.)
Please also note the age at which they were affected.

Illness/Condition	Grandmother	Grandfather	Mother	Father	Brothers	Sisters	Sons	Daughters	None
Coronary Artery Disease									
Diabetes									
Melanoma									
Prostate Cancer									
Breast Cancer									
Colon Cancer									
Colon Polyps									
Alzheimer's Disease									
Psychiatric Illness									
Bipolar Disease									
Suicide									
Other									

SOCIAL HISTORY		
Occupation:	Employer:	
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced	Spouse's Name:	
Number of Children:	Ages:	
What are you hobbies?		
Exercise	Do you exercise regularly? ❑ Yes ❑ No	Type of exercise:
	How Long (minutes)?	How often?

Lifestyle	Are there any activities of daily living such as bathing, eating, dressing etc. with which you need assistance?		☐ Yes	☐ No
	If yes, explain			
	Religion:	Name of Church:		
	What is your sexual preference?	❑ Heterosexual ❑ Homosexual ❑ Bisexual ❑ Other		
Alcohol	**Do you drink alcohol?**		☐ **Yes**	☐ **No**
	If yes, what kind?			
	How many days per week do you drink?	How many drinks per day?		
	What is the most number of alcoholic beverages you will have in a 24-hour period?			
Tobacco	**Do you or have you used Cigarettes, Pipe, Cigar, Snuff, or Chew?**		☐ **Yes**	☐ **No**
	Do you smoke now?		☐ **Yes**	☐ **No**
	How many cigarettes per day do you/did you smoke?	# of years:	year quit:	
	Do you use smokeless tobacco now?		☐ **Yes**	☐ **No**
	On average how much smokeless tobacco per day do you /did you use?	# of years:	year quit:	
Drugs	**Do you or have you used Marijuana or recreational drugs?**		☐ **Yes**	☐ **No**
	If yes, please list:	Current Use:	Prior Use:	

Referred By: _____

(*Name of person or marketing resource)*

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Name of person completing this form _____ Relationship to patient _____

Patient/Legal Guardian Signature _____ Date _____

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