

EMR Health History Questionnaire

Patient Name: _____

Birthdate: _____

Preferred Name: _____

Current Active Problems (i.e. hypothyroid, depression, hypertension, diabetes)

Type

Previous Hospitalizations, Surgery, Serious Injury

Type

Year

Current Medications:

Name

Dose

Name

Dose

Drug Allergies: Yes / No

Name

Reaction

Name

Reaction

Name of Preferred Pharmacy you use, address & phone number:

Do you prefer to have a medical assistant present when the doctor examines you?

Yes / No

Past or Present Illness

Comments:

Diabetes:	Yes	No	_____
Thyroid:	Yes	No	_____
High Blood Pressure:	Yes	No	_____
Heart Disease:	Yes	No	_____
Headaches:	Yes	No	_____
Stroke:	Yes	No	_____
Respiratory/Asthma	Yes	No	_____
Stomach or Bowel Problems:	Yes	No	_____
Blood Transfusions:	Yes	No	_____
Blood Disorder:	Yes	No	_____
Bladder Infection:	Yes	No	_____
Uncontrolled Loss of Urine:	Yes	No	_____
Mental Health:	Yes	No	_____
Hyperlipidemia:	Yes	No	_____
Osteopenia/Osteoporosis:	Yes	No	_____
Arthritis:	Yes	No	_____
Cancer:	Yes	No	_____
Endometriosis:	Yes	No	_____
Fibroids:	Yes	No	_____
Sexual Abuse:	Yes	No	_____
Other:	Yes	No	_____

Health Habits and Risk

