

Ashburn Family Healthcare, PLLC

Confidential Health History Questionnaire

Welcome to Ashburn Family Healthcare. We greatly appreciate your choosing us to provide care for your family. Please answer following questions about your health.

PERSONAL INFORMATION: Patient Name: _____ Age: _____
If child, name of parent(s) or guardian(s): _____
Occupation: _____ Marital Status: _____ Name of Spouse/ Partner: _____
Number of Children: _____ Children's Names and Age: _____
Who else lives in your household? _____

MEDICAL INFORMATION: When was your last Complete Physical Examination? _____
Are you currently under care of a physician for any reason? Yes No If yes, the reason _____
Are you taking any prescription or over the counter medications? Yes No If yes, list the names and dosages: _____

Have you ever been hospitalized? Yes No If yes, When and Why? _____
Have you had any operations or procedures? Yes No If yes, please list: _____
Are you allergic to any medication or food? Yes No If yes, list the name(s): _____
Are your immunizations up-to-date? Yes No Date of last tetanus shot: _____

Do you or any of your family members have any of the following conditions?

Anemia	Self <input type="checkbox"/> Family <input type="checkbox"/>	_____	Kidney Disease	Self <input type="checkbox"/> Family <input type="checkbox"/>	_____
Allergies/Hay Fever	Self <input type="checkbox"/> Family <input type="checkbox"/>	_____	Liver Disease	Self <input type="checkbox"/> Family <input type="checkbox"/>	_____
Asthma	Self <input type="checkbox"/> Family <input type="checkbox"/>	_____	Osteoporosis	Self <input type="checkbox"/> Family <input type="checkbox"/>	_____
Arthritis	Self <input type="checkbox"/> Family <input type="checkbox"/>	_____	Respiratory Disease	Self <input type="checkbox"/> Family <input type="checkbox"/>	_____
Anxiety/Depression	Self <input type="checkbox"/> Family <input type="checkbox"/>	_____	Skin Disease	Self <input type="checkbox"/> Family <input type="checkbox"/>	_____
Alcoholism	Self <input type="checkbox"/> Family <input type="checkbox"/>	_____	Stomach/Colon Disease	Self <input type="checkbox"/> Family <input type="checkbox"/>	_____
Cancer, Type _____	Self <input type="checkbox"/> Family <input type="checkbox"/>	_____	Stroke	Self <input type="checkbox"/> Family <input type="checkbox"/>	_____
Diabetes, Type _____	Self <input type="checkbox"/> Family <input type="checkbox"/>	_____	Seizure Disorder	Self <input type="checkbox"/> Family <input type="checkbox"/>	_____
High Blood Pressure	Self <input type="checkbox"/> Family <input type="checkbox"/>	_____	Thyroid Disease	Self <input type="checkbox"/> Family <input type="checkbox"/>	_____
High Cholesterol	Self <input type="checkbox"/> Family <input type="checkbox"/>	_____	Venereal Disease (STD)	Self <input type="checkbox"/>	_____
Heart Attack	Self <input type="checkbox"/> Family <input type="checkbox"/>	_____	Other	_____	_____

Musculoskeletal Conditions:

Please describe any past or current musculoskeletal conditions such as muscle pulls, sprains, fractures, surgery etc.

Females Only: Date of Last menstrual period _____ Are your periods regular? _____
Number of Pregnancies _____ Miscarriages/Terminations _____ Pregnancy Complications: _____
Date of Last Pap smear _____ Normal Abnormal If abnormal, treatment? _____
Date of Last Mammogram _____ Normal Abnormal If abnormal, treatment? _____

SMOKING HABITS: Non-smoker Former smoker; Date quit: _____ Current smoker
Number of years smoking: _____ Number of packs per day: _____ Cigar, pipe or chewing tobacco

ALCOHOL USE: Do you drink any alcohol? Yes No if yes, what type? _____
How much do you consume in one week? _____ Have you ever thought about quitting? Yes No

DRUG USE: Have you ever used any illegal drugs? Yes No if yes, what type? _____ When? _____

NUTRITION: How would you describe your current nutritional habits? _____
Are you on any specific food / dietary plan at this time? Yes No _____
Do you take dietary supplements? Yes No _____
Have you experienced a recent weight gain or loss? Yes No _____
Do you drink Coffee, Tea, Soda or other caffeinated beverages? Yes No if yes, how much per day? _____

EXERCISE HABITS: How often do you exercise?

None Sporadic 1-3 x a week 4-5 x a week

What activities do you like to do for exercise? _____

STRESS: How would you describe your stress level?

At Home Minimal Average Moderate Extreme
At Work Minimal Average Moderate Extreme

Do you work more than 40 hours a week? Yes No
Have you recently noticed an increase in sadness or gloominess? Yes No
Have you lost interest in enjoyable activities? Yes No
Has anybody ever hit you or tried to injure you? Yes No
Have you ever been sexually or physically abused? Yes No

SAFETY:

Do you avoid excess exposure to sun and use sunscreen when you are outside? Yes No
Are you aware of the dangers of narcotics and other addictive drugs? Yes No
Do you practice dental health by brushing, flossing, and regular dental visits? Yes No
Do you practice safe sex? Yes No
Do you wear a seatbelt at all times when driving or riding in a car? Yes No
Do you use protective equipment for contact sports or when needed at your job? Yes No
Do you have smoke detectors at home and do you check them periodically? Yes No
Do you have a gun in your home? Yes No
 If yes, do you keep it out of reach of children? Yes No
Have you been exposed to blood, body fluids, chemicals, excessive loud noise or radioactive materials at home or work? Yes No
Have you recently traveled out of the country or are you planning to do so? Yes No
Would you like more information on any of the above topics? Yes No

DO YOU HAVE A LIVING WILL?

If yes, please bring a copy for your medical records. Yes No

Would you like for us to be able to discuss your health care information with any family members, relatives or friends? Yes No **If yes, please complete following section:**

By signing this form, I authorize Ashburn Family Healthcare to release/discuss all protected health information about me to:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Comments: _____

Signed: _____ Date: _____