Avere Healthcare Clinic

HEALTH HISTORY QUESTIONAIRE (Rev 9/16/11)

Patient Name: _____ Date of Birth: _____

Main reason for today's visit: _____

Other concerns: _____

Do you have any of the following allergies: ☐ Adhesive ☐ Latex ☐ Medications (list on line below)

_____

Please list prescription/over the counter medications you are taking, including the dosages and amount taken daily:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list all hospitalizations, reason hospitalized, and the year hospitalized	
Reason Hospitalized (Surgery, Observation, etc)	**Year**

FAMILY MEDICAL HISTORY

Please complete the following if your parents' medical history is known:

Major Health Problems

☐ Prostate Cancer ☐ Colon Cancer ☐ Stroke
☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure
☐ Other: _____

	Age if Living	Age at Death	Cause of Death
FATHER	_____	_____	_____
MOTHER	_____	_____	_____

☐ Breast Cancer ☐ Uterine Cancer ☐ Stroke
☐ Ovarian Cancer ☐ Colon Cancer ☐ Heart Disease
☐ High Blood Pressure ☐ Diabetes
☐ Other: _____

SOCIAL HISTORY

TOBACCO USE

☐ I have never used tobacco (skip to alcohol section) ☐ I quit using tobacco ☐ I currently use tobacco

If you no longer use tobacco, what kind did you use? _____ How much per day? _____

How long did you use it? _____ When did you quit? _____

If you currently use tobacco, what kind do you use? ☐ Cigarettes ☐ Cigars ☐ Smokeless ☐ Pipe

How much per day? _____ When did you start? _____

ALCOHOL USE

I drink the following: ☐ Beer ☐ Wine ☐ Liquor ☐ I do not drink Frequency: ☐ Daily ☐ Monthly Quantity: _____

ILLICIT/RECREATIONAL DRUGS

Have you ever used illicit/recreational drugs? ☐ Yes ☐ No

Do you currently use illicit/recreational drugs? ☐ Yes ☐ No What kind? _____ How often? _____

I acknowledge that the information that I provided above is accurate.

_____ _____ _____

Signature Printed Name Date