Please note: To fill out this form using the editable fields in the PDF, you must first save to your computer and open using Adobe Reader.

Mile High Family Medicine
HEALTH HISTORY QUESTIONNAIRE

All questions in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*: ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Occupation:	**Date of last physical exam:**
How did you hear about us? ❑ Friend/Family ❑ Internet ❑ Insurance List ❑ Other:	

PERSONAL HEALTH HISTORY

Immunizations & Dates if known	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ Other

Long-term medical problems that other doctors have diagnosed you with:

- ☐ High Blood Pressure
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ High Cholesterol
- ☐ Cancer (*list type(s)):* ____________________
- ☐ Rheumatoid Arthritis
- ☐ Other Autoimmune Disorders: ____________________
- ☐ Hypothyroidism
- ☐ Hyperthyroidisms
- ☐ Seasonal Allergies
- ☐ Migraines
- ☐ COPD
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Seizure Disorder
- ☐ Asthma
- ☐ Anemia
- ☐ Other: ____________________

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name of the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	☐ Energy Drink	
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – packs/day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

	Condition	Family Member(s)
☐	High Blood Pressure	
☐	Heart Attack	
☐	High Cholesterol	
☐	Stroke	
☐	Bleeding Disorder	
☐	Rheumatoid Arthritis	
☐	Diabetes (Type I or II)	
☐	Thyroid Disorder	
☐	Asthma	
☐	Cancer (list type)	
☐	Other	

Surgeries		
Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No