



HEALTH QUESTIONNAIRE:

Patient Name _____ Date of Birth ___/___/___
 Date ___/___/___
 Reason for Visit _____

Medication (List Frequency and Strength)

CIRCLE- No Medication

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Allergies to Medication (List Medication/Reactions)

CIRCLE- No Allergies

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
|----------|----------|

Chronic Conditions/ Illnesses

CIRCLE- None

Asthma Cancer Diabetes Heart Conditions High Cholesterol
 High Blood Pressure Osteoporosis Epilepsy Bleeding Disorder
 Other: _____

Surgeries and Procedures

- | | |
|----------|------------------|
| 1. _____ | Date ___/___/___ |
| 2. _____ | Date ___/___/___ |
| 3. _____ | Date ___/___/___ |

Social History

Occupation? _____

- | | | |
|--|--|------------------------|
| Smoke or Chew Tobacco? | <input type="checkbox"/> Yes <input type="checkbox"/> No | packs per day? _____ |
| Quit Smoking? | <input type="checkbox"/> Yes <input type="checkbox"/> No | years smoked? _____ |
| Alcoholic Drinks? | <input type="checkbox"/> Yes <input type="checkbox"/> No | drinks per week? _____ |
| Illegal Drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | what type? _____ |
| Past Drug Use? | <input type="checkbox"/> Yes <input type="checkbox"/> No | year quit? _____ |
| Do you drink caffeine? | <input type="checkbox"/> Yes <input type="checkbox"/> No | cups per day? _____ |
| Do you exercise regularly? | <input type="checkbox"/> Yes <input type="checkbox"/> No | what type? _____ |
| Do you wear your seatbelt? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Do you have a Living Will or Advance Directive for Healthcare? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |



WOODBURY MEDICAL GROUP
 Family Medicine & Urgent Care
 6340 Irvine Boulevard - Irvine, CA 92620

Family History

	Age	Medical Conditions	
Mother		<input type="checkbox"/> None	<input type="checkbox"/> Deceased
Father		<input type="checkbox"/> None	<input type="checkbox"/> Deceased
Sister		<input type="checkbox"/> None	<input type="checkbox"/> Deceased
Sister		<input type="checkbox"/> None	<input type="checkbox"/> Deceased
Brother		<input type="checkbox"/> None	<input type="checkbox"/> Deceased
Brother		<input type="checkbox"/> None	<input type="checkbox"/> Deceased

Review of Systems: PLEASE CIRCLE the following that you may experience.

- | | | | |
|-----------------------------|----------------------|--------------------------------------|-------------------------|
| Asthma | Enlarged glands | Insomnia | Vomiting |
| Bloody or black stools | Excessive bleeding | Jaundice | Weight gain/loss |
| Change in bowel habits | Fainting | Joint pain/swelling | Varicose veins |
| Change in pigment of skin | Fatigue | Muscle cramping | Unsatisfactory sex life |
| Change in vision/hearing | Fever | Muscle weakness | Prior psychiatric care |
| Chest pain | Frequent colds | Neck stiffness | Loss of bladder control |
| Chronic sinus/ear problems | Frequent diarrhea | Nosebleeds | |
| Cough | Frequent indigestion | Palpitations | |
| Difficulty breathing | Frequent urination | Paralysis | |
| Difficulty walking | Headaches | Poor concentration | |
| Difficulty walking 2 blocks | Heart murmur | Poor wound healing | |
| Difficulty urinating | Hemorrhoids | Rashes | |
| Dizziness | Hives | Spitting up blood | |
| Easy bruising | Hopelessness | Swelling in hands/feet | |
| Eczema | Hot flashes | Loss of interest in usual activities | |

Immunizations

Last Tetanus Booster Shot- Date ___/___/___ Last Flu Shot- Date ___/___/___

Over 65 years: Last Pneumonia Shot- Date ___/___/___

Health Screening

Last Cholesterol Test ___/___/___ Last EKG ___/___/___

Last Occult Blood(stool test) ___/___/___

Over 50 years: Last Colonoscopy ___/___/___



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Women's Health

First day of last menstrual period ____/____/____ Currently Pregnant? Yes No

Age you started having periods? _____ Breast Feeding? Yes No

How many pregnancies have you had? _____

How many children have you had? _____

Date of last Pap smear ____/____/____

Date of last abnormal Pap smear ____/____/____

Date of Hysterectomy ____/____/____ Reason for Hysterectomy _____

Any gynecologic surgeries? _____

Date of Last Mammogram ____/____/____ Any Abnormalities _____

Have you had a Bone Density? Yes No If yes, date of last scan ____/____/____

Pediatric Health- (18years and younger)

Is your child up to date on all Immunizations? Yes No

Was he/she born - Full Term/Premature

C-Section / Vaginal birth

Any complications with the birth? Yes No If yes, please list _____
