

Headland  
Family  
Medicine



Health History Form

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These questions are designed to help us get to know you, and to make your first visit to Headland Family Medicine more efficient and productive. **THIS QUESTIONNAIRE IS FOR YOU.** Many people find it helpful to organize their thoughts and make lists of important medical issues before seeing their practitioner. Feel free to skip any questions you do not find helpful, and do not include any information you would not want to include in your medical record.

**Your Name:** \_\_\_\_\_ **Date of appointment:** \_\_\_\_\_

**REASON FOR APPOINTMENT**

Please describe your reason(s) for making this appointment and what you hope to accomplish in your initial visit:

**CURRENT MEDICAL ISSUES**

Please list any current medical issues you have, as well as conditions you are currently being treated for:

**PAST MEDICAL HISTORY AND SURGICAL HISTORY**

Please list important health problems or events in the past or significant medical studies or test you have had:

**MEDICATIONS**

Do you take any prescribed medications? Please list medications you take daily, as well as any medications you use “as needed”. Include the dose and regimen (how often).

**SUPPLEMENTS**

Do you regularly take over-the-counter medications, herbs, vitamins, or other supplements? Please list supplements you take on a regular basis.

**ALLERGIES**

Please list any known medication allergies or sensitivities, including reactions you may have had in the past to medications.

**FAMILY MEDICAL HISTORY**

Please list your immediate “blood relative” family (Mother, Father, Siblings). Note if they are deceased, (cause and year), and list any major medical problems they have. In particular, please note if they have a history of cancer, diabetes, heart disease, hypertension, or obesity.

**SOCIAL HISTORY**

Marital Status: Single/ Married / Separated / Divorced / Widowed

Your Occupation:

Company / Position:

Significant hobbies, activities, or interest:

**HEALTH HABITS**

Do you follow a particular eating plan or diet?

Do you smoke or chew tobacco? No Cigarettes Cigars Pipe Chew

If yes, how much do you use daily?

What year did you start?

If you are a past smoker, when did you quit? For how long did you smoke?

Do you drink alcohol? No Beer Wine Other

About how much? Rarely "Social" <1 drink/day Daily, 1-2 drinks More

Please discuss any concerns you have about your alcohol intake with your practitioner.

Past or present recreational drug use, especially cocaine and IV drugs, can have important implications for your health. Please discuss recreations drug use with your practitioner at the time of your visit if this is an issue for you.

Do you get regular exercise? (Please circle)

Elite training regimen/intense exercise schedule

Vigorous fitness program up to 5 times weekly

Some vigorous exercise once or twice a week or “physical job”

Try to be active / walk, take stairs

Inactive, rarely exercise

Do you have a spiritual practice or stress-reduction technique that is important to you? (Please circle)

Meditation / Prayer / Organized religious affiliation / Yoga / Biofeedback / Other

Do you use complementary or alternative medical therapies for your health issues or wellness?  
(Please circle)

Chiropractic

Acupuncture

Massage therapy

Yoga

Homeopathy

Other?

### HEALTH MAINTENANCE

Please bring to your appointment any records you may have about the following:

- Immunization records
- Mammogram (most recent)
- Pap test (most recent)
- PSA (prostate cancer screening) test
- Colonoscopy
- Cholesterol or other lab test
- Other test or records pertaining to your current medical concerns

We look forward to meeting you at your initial Headland Family Medicine visit!