North Olympic Healthcare NETWORK

NORTH OLYMPIC HEALTHCAR NETWORK
HEALTH QUESTIONNAIRE

DATE**:** _____ NAME (PRINT): _____

DATE OF BIRTH: _____ AGE: _____ GENDER: ☐ **M** ☐ **F** SEX AT BIRTH ☐ **M** ☐ **F**

HEALTH HISTORY: (*Circle and/or fill in***)**

Major Illnesses: None Diabetes High Blood Pressure Heart Trouble Cancer Arthritis
Seasonal Allergies Other _____

Major Surgeries: None Tonsils Appendix Hernia Gallbladder Hysterectomy
Other _____

Major Injuries: None Broken Bones Head Injuries
Other _____

Pregnancies: ☐ NO ☐YES
Number vaginal deliveries: _____ Number cesarean deliveries: _____
Number of miscarriages: _____ Date(s): _____

Social: Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Number of children and ages: _____
Tobacco: ☐ NO ☐ YES **Type**: ☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Chew
Alcohol: ☐ NO ☐ YES # of drinks per day _____ week _____ month _____
Occupation: _____
Were you born outside the USA? ☐ NO ☐YES If yes, where? _____

Immunizations: *Date last received (if known)*
Tetanus _____ Flu _____Hep B _____ Shingles _____Pneumonia_____

Annual Care: *Date of last screening (if known)*
Pap Smear _____ Mammogram _____ Colonoscopy _____

MEDICATION HISTORY: List **ALL** medications you take every day (*prescribed and over the counter*):
_____
_____

List any **DRUG** allergies you have: _____

FAMILY HISTORY: Check the box(s) of anyone in your immediate family who has or had any of the following:

Heart Disease: ☐ Parent ☐ Sibling ☐ Child
High Cholesterol: ☐ Parent ☐ Sibling ☐ Child
High Blood Pressure: ☐ Parent ☐ Sibling ☐ Child
Stroke: ☐ Parent ☐ Sibling ☐ Child
Diabetes: ☐ Parent ☐ Sibling ☐ Child
Mental Illness: ☐ Parent ☐ Sibling ☐ Child
Breast Cancer: ☐ Parent ☐ Sibling ☐ Child
Colon Cancer: ☐ Parent ☐ Sibling ☐ Child
Prostate Cancer: ☐ Parent ☐ Sibling ☐ Child
Ovarian/Uterine or Cervical: ☐ Parent ☐ Sibling ☐ Child

Anything else you would like to share regarding your health history? _____
_____
_____