**HOMA FAMILY MEDICINE**

**HEALTH QUESTIONNAIRE**

 **Today’s Date**:\_\_\_/\_\_\_/\_\_\_

**Patient Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_/\_\_\_/\_\_\_ **Age:** \_\_\_

**Briefly state the reason for your visit**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Past Medical History** (Check all that apply):

Hypertension 

Diabetes 

Heart disease 

Thyroid disease 

Autoimmune disease 

Cancer 

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medications: (Please List ALL medications including supplements)**

|  |  |  |  |
| --- | --- | --- | --- |
| Medication Name | Dosage | Frequency | Reason for taking this medication |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |

**Medication Allergies : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family Medical History: (Please list all diseases and conditions)**

Father’s Medical History:

Current Age:\_\_\_\_ OR Age Deceased:\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Medical History:

Current Age:\_\_\_\_ OR Age Deceased:\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings’ Medical History:

Current Age:\_\_\_\_ OR Age Deceased:\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grandparents’ Medical History:

 Current Age:\_\_\_\_ OR Age Deceased:\_\_\_\_

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**Social History:**

1. Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, how many packs per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Do you drink alcohol? \_\_\_\_\_\_\_\_ If yes, how many drinks per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Do you use any illicit drugs? \_\_\_\_\_\_ If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Do you exercise? \_\_\_\_\_ If yes, how many times per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize HOMA Family Medicine to forward my insurance company medical reports and information which they may request. I also authorize my insurance company to forward any necessary information to HOMA Family Medicine may request to settle claim issues.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient (legally responsible party) Date