Crowley Medical Assoicates
Health History Questionnaire

Patients Name:		DOB:
Previous Doctor:		Sex: ○ Female ○ Male

Care Team:	
Cardiologist:	
Gastroenterologist:	
Otolaryngologist/ENT:	
Optometrist:	
Urologist:	
OBGYN:	
Neurologist:	
Other:	

Personal Health History Check all that apply				
○ Anemia	○ Cancer	○ Glaucoma	○ Kidney Disease	○ Prostate Problem
○ Anxiety	○ Depression	○ Gout	○ Liver Disease	○ Rheumatologic
○ Arthritis	○ Diabetes/prediabetes	○ Heart Disease	○ Migraines	○ Stroke
○ Arrhythmia	○ Emphysema/COPD	○ High Cholesterol	○ Memory Issues	○ Thyroid Problems
○ Asthma	○ Epilepsy	○ Hypertension	○ Osteoporosis	○ Ulcers
○ Bronchitis	○ Eating Disorder	○	○	○

Allergies: Drug/Food/Enviromental	
Drug Name:	**Reaction:**

Medications: Please list prescribed Drugs and over the counter drugs					
Drug Name:	Strength	Frequency Taken	Drug Name:	Strength	Frequency Taken:
1.			7.		
2.			8.		
3.			9.		
4.			10		
5.			11.		
6.			12.		

Surgical History		
Year	Surgery Type/Reason	Hospital

Other Hospitalizations		
Year	Reason for admission	Hospital

Family History			
Relation	Age	Age At Death	Significant Health Problems
Father			
Mother			
Brothers	___ ___ ___ ___	_____ _____ _____ _____	_____ _____ _____ _____
Sisters	___ ___ ___ ___	_____ _____ _____ _____	_____ _____ _____ _____
Maternal Grandparent	___	_____	_____
Paternal Grandparent	___ ___	_____ _____	_____ _____

Social History
Tobacco Use: O: Never O: Former O: Current every day user Current Smoker: Packs/day:_____ # of years_____ Former Smoker: Year Quit: _____ # of years _____ #Packs/day_____ Smokeless Tobacco: O Yes O: No If yes how many years:_____ Electronic Tobacco Use: O: Yes O: No If yes how many years:_____ Nicotine Usage: O: Yes O:No If yes how many years:_____
Alcohol Usage: Do you drink alcohol: O Yes O: No If yes what kind: _____ How many drinks per week: _____
Drug Use: Do you currently use recreational drugs including marijuana? O Yes O: No If yes, what drugs are currently being used and how often:_____ Have you ever given yourself street drugs with a needle? O Yes O: No
Personal Safety: Do you live alone? O Yes O: No Do you have frequent falls? O Yes O: No Do you have vision loss? O Yes O: No Do you have hearing loss? O Yes O: No

Mental Health	
Is stress a major problem for you?	O Yes O: No
Do you feel depressed?	O Yes O: No
Do you panic when stressed?	O Yes O: No
Do you have problems with eating or your appetite?	O Yes O: No
Do you cry frequently?	O Yes O: No
Do you have trouble sleeping?	O Yes O: No
Have you ever thought about hurting yourself?	O Yes O: No
Have you ever attempted suicide?	O Yes O: No
Have you ever been to a counselor?	O Yes O: No

Immunizations History	
Immunization	Most Recent Date
TD or TdaP	
Pneumonia: Prevnar 13 Pneumonia Vax 23 Prevnar 20	
Shingles: Zostavax Shingrix:	
RSV: Arexvy Resvia Abrysvo	
Influenza	
Covid:	

Health Maintenance Screening test	
	Most recent date/ Location
Colonoscopy:	
Mammogram:	
Dexa Scan:	
Pap Smear:	