Please Fill Out

Providence Plaza Internal Medicine

Initial Health Questionnaire

Patient Name	Age	Sex	Date of Birth	Marital Status
			/ /	❑ M ❑ S ❑ W ❑ Div ❑ Sep

1. List your medications, including dose & how you take it.
   (please include all medications including over-the-counter preparations, topicals & vitamins)

2. List all allergies, sensitivities or intolerances you have to medications.
   a. ______ b. ______ c. ______
   d. ______ e. ______ f. ______

3. Please list all operations and hospitalizations with their appropriate year and physician in charge. Use other side if needed.

ILLNESS/INJURY/OPERATION	YEAR	ATTENDING PHYSICIAN

4. List medical illnesses.

5. Social history
   ❑ Employed ❑ Retired ❑ Occupation ______
   ❑ Student Number of children ______

	What	How Much	How Long	Year Quit
Do you or have you ever used tobacco?				
Do you use alcohol?				
Do you use caffeine?				
Do you use drugs?				
Do you exercise?				

6. Healthcare maintenance
   Last physical exam______ PAP ______ Mammogram ______ Bone density ______
   Colonoscopy ______ Prostate exam ______ Flu shot ______ Pneumovax______ Tetanus ______

7. Family history
   ❑ Heart attack ❑ Stroke ❑ Hypertension ❑ Diabetes
   ❑ Colon cancer ❑ Breast cancer ❑ Ovarian cancer ❑ Prostate cancer

	Family Health	Current Age	Good	Fair	Poor	Died at Age	Disease/Cause of Death
Father			❑	❑	❑	❑	
Mother			❑	❑	❑	❑	
Brothers			❑	❑	❑	❑	
& Sisters			❑	❑	❑	❑	
			❑	❑	❑	❑	