HARDER family practice P.A.

MEDICAL HISTORY QUESTIONAIRE

Today's Date: _____ **Date Of Birth:** _____

Name: _____ _____ _____
Last First M. Initial

What are we seeing you for today? _____

_____

Please list any previous or current MEDICAL CONDITIONS: _____

_____

Please list any DRUG ALLERGIES you have:

_____

Please list any MEDICATIONS you are currently taking:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Please list any SURGERIES you have had and the YEAR they were performed:

1. _____ _____ Year 4. _____ _____ Year
2. _____ _____ Year 5. _____ _____ Year
3. _____ _____ Year 6. _____ _____ Year

Family History: **Living/Deceased** **Illnesses**

Father: _____ _____

Mother: _____ _____

Marriage/Family Status:

☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Remarried** ☐ **Blended Family**

Place of Employment (if applicable): _____

Please list all family members that reside in your home (i.e.: children, step-children, grandparents, foster children, etc.) FIRST and LAST names: _____

Do you use either of the following?

TOBACCO: ☐ **No** ☐ **Yes _____ packs/day** ☐ **Previous smoker** ☐ **Chewing tobacco**

ALCOHOL: ☐ **No** ☐ **Socially** ☐ **Regular Use** _____ **Drinks per day**

How did you hear about us? ☐ **Friend/Neighbor** ☐ **Relative** ☐ **Phone Book** ☐ **Online** ☐ **Advertisement**

Signature _____ **Date** _____ **Revised 09-2019**