Nursing Health & Wellness

HEALTH HISTORY QUESTIONNAIRE

Date:
Dates Revised:

Reason for visit:

Name *(Last, First)* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Immunizations Dates	☐ Tetanus	☐ Pneumonia ☐ RSV
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza ☐ Covid	☐ MMR *Measles, Mumps, Rubella*

Past Medical History

Surgeries and Hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name of the Medication	Strength/mg of medication	How often do you take the medication?

Allergies to medications/food

Name of the Medication/food	Describe the reaction you experienced.

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HEALTH HABITS AND PERSONAL SAFETY				
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.				
Exercise	☐ Type			
Alcohol	Do you drink alcohol? If yes, what kind? _____	☐ Yes	☐ No	
	How many drinks per week?			
Tobacco	Do you use any form of tobacco product? (Vaping, smokeless tobacco, etc…)	☐ Yes	☐ No	
	☐ Cigarettes – packs./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ Number of years tobacco has been used _____	☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No	
	Do you have vision or hearing loss?	☐ Yes	☐ No	

Family History	Father	Mother	Sibling
Alcoholism			
High blood pressure			
Asthma			
Kidney problems			
Bleeding disorder, anemia			
Mental illness			
Cancer			
Migraine			
Diabetes			
Osteoporosis			
Glaucoma			
Stroke			
Epilepsy/Convulsions			
Thyroid disease			
Heart disease (age onset)			
Hyperlipidemia			
Allergies			
Muscle/Bone disease			
Other			

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Revised 3/2024

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