

RETURN PATIENT HEALTH HISTORY QUESTIONNAIRE

Patient Name _____ **DOB** _____ **Date** _____

Who is your Primary Care Physician? _____

Preferred Pharmacy Name and Location _____

Updated Address and/or Phone Number _____

Height _____ Weight _____

May we leave a detailed message on your voicemail? **Y N**

Updates to Medical & Surgical History

Medications (If this space is too small, please give us a list of your medications with the following information)

Name of Medication	Dose	Frequency	Route (i.e. by mouth, injection, etc.)

Allergies (If this space is too small, please give us a list of all allergies and reactions)

Allergy (include drug allergies)	Reaction

Please answer the following questions about your health habits:

Have you ever been a tobacco user? **Y N**

If YES, when did you start using tobacco? Approx. date: _____

If you have quit using tobacco, when did you quit? Approx. date: _____

Number of packs per day _____

Total years using tobacco _____

For those 64 and older:

Do you have a health care proxy in the event you are unable to make your own medical decisions? **Y N**

Do you have a living will? **Y N**

Review of Systems: Have you experienced any of the following within the last ten days? (Please circle Y or N)

- | <table style="width: 100%; border: none;"> <tr> <th style="text-align: left;">Yes</th> <th style="text-align: left;">No</th> <td> </td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Rash</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Chest Pain</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Fever or Chills</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Unintentional Weight Loss (within the last 6 months)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Sore Throat</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Currently pregnant or breastfeeding</td> </tr> </table> | Yes | No | | <input type="checkbox"/> | <input type="checkbox"/> | Rash | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> | Fever or Chills | <input type="checkbox"/> | <input type="checkbox"/> | Unintentional Weight Loss (within the last 6 months) | <input type="checkbox"/> | <input type="checkbox"/> | Sore Throat | <input type="checkbox"/> | <input type="checkbox"/> | Currently pregnant or breastfeeding | <table style="width: 100%; border: none;"> <tr> <th style="text-align: left;">Yes</th> <th style="text-align: left;">No</th> <td> </td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Blurry Vision</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Joint Aches</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Headaches</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cough</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Depression</td> </tr> </table> | Yes | No | | <input type="checkbox"/> | <input type="checkbox"/> | Blurry Vision | <input type="checkbox"/> | <input type="checkbox"/> | Joint Aches | <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Cough | <input type="checkbox"/> | <input type="checkbox"/> | Depression |
|---|--------------------------|--|--|--------------------------|--------------------------|------|--------------------------|--------------------------|------------|--------------------------|--------------------------|-----------------|--------------------------|--------------------------|--|--------------------------|--------------------------|-------------|--------------------------|--------------------------|-------------------------------------|---|-----|----|--|--------------------------|--------------------------|---------------|--------------------------|--------------------------|-------------|--------------------------|--------------------------|-----------|--------------------------|--------------------------|-------|--------------------------|--------------------------|------------|
| Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Rash | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever or Chills | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Unintentional Weight Loss (within the last 6 months) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore Throat | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Currently pregnant or breastfeeding | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurry Vision | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Aches | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cough | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |