2480 Berkshire Parkway
Clive, Iowa 50325
(515) 225.2578
Fax: (515) 255.2598

Preventative Health Clinic
Health Questionnaire

Name: ______________________ DOB: __________ Age: ________ Date: ______

Reason for appointment? ______________________________________

How did you hear about us? ______________________________________

Date of last physical: ______________________

PAST MEDICAL HISTORY

List all significant diagnoses, illness/injuries and hospitalizations with date:

Problem	Date	Problem	Date

List all surgeries including Appendix and tonsils:

Surgery	Date	Surgery	Date

Medications (Currently Taking)

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Allergies	Reaction

(continued on back)

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Family History

Have you or any blood relatives had:

High Blood Pressure	Yes	No	______________________________
High Cholesterol	Yes	No	______________________________
Heart Problems	Yes	No	______________________________
Stroke	Yes	No	______________________________
Diabetes	Yes	No	______________________________
Cancer	Yes	No	______________________________
Seizures	Yes	No	______________________________
Suicide/Mental Disorder	Yes	No	______________________________
Bleeding Tendencies	Yes	No	______________________________
Asthma	Yes	No	______________________________
Tuberculosis	Yes	No	______________________________

Social History/Habits

Have you ever smoked? Yes No ______Packs per day ______Years Quit _____

How much alcohol do you drink weekly? ____

History of alcoholism? Yes No

Any current or history of drug use? Yes No Specify ______________________________

Last Tetanus Shot? __________________________

Women Only:

Last Menstrual Period: ____________________________

Current Birth Control: ____________________________

Number of pregnancies: ____________________________

Number of deliveries: ____________________________

Date of Last Mammogram and PAP smear: __________________________

Do you do self-breast exams? ______________

____

Patient's Signature Date