VIGILANT HEALTH

Health Questionnaire

Name:	**Date of Birth:**
How did you hear about us/who referred you?	
Primary Physician:	
Other Specialists:	
Current Medications: *(Please list name of medication, strength, and frequency of Prescription and Over the Counter Medications)*	

MEDICATION ALLERGIES?	**Yes**	**No**	
If **YES**, name of medication: What type of reaction did you have to it?			
PHARMACY NAME/LOCATION:			

PAST MEDICAL HISTORY (Please check all that apply to you):

☐ Diabetes	☐ Heart Attack	☐ COPD	☐ Kidney Disease
☐ Hypertension	☐ Stroke	☐ Asthma	☐ Thyroid Disease
☐ High Cholesterol	☐ Heart Failure	☐ Cancer	☐ Other:
☐ Obesity	☐ Circulation Problems	☐ Depression/anxiety	☐ Other:

Past Surgeries: *(Please list type of surgery and approximate date)*

Immunizations			**OB/GYN History**
Pneumonia:	☐ **Yes**	☐ **No**	Number of pregnancies:
Tetanus:	☐ **Yes**	☐ **No**	Number of births:
Hepatitis A:	☐ **Yes**	☐ **No**	Number of abortions/miscarriages:
Hepatitis B:	☐ **Yes**	☐ **No**	Contraception method:
Flu:	☐ **Yes**	☐ **No**	Last menstrual period:
Shingles:	☐ **Yes**	☐ **No**	
Covid-19:	☐ **Yes**	☐ **No**	

Preventative Maintenance

Colonoscopy:	Date	Results	Doctor
Mammogram:	Date	Results	Doctor
Pelvic/Pap:	Date	Results	Doctor
Prostate Exam or PSA (circle)	Date	Results	Doctor

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SOCIAL HISTORY				
☐ Single	☐ Married	☐ Domestic Partnership	☐ Divorced	☐ Widowed
JOB TITLE/OCCUPATION:				
Tobacco Use: Never used Formerly used (year quit: _____) Currently use Type of tobacco: _____ How much per day? _____				
Do you use alcohol?	Which type?	How often?		

FAMILY HISTORY		
Father	**Living/Deceased**	**Age**
Mother	**Living/Deceased**	**Age**

Family Illnesses

	Father	Mother	Sibling	Child	Grandparent
Diabetes					
High blood pressure					
High cholesterol					
Cancer					
Kidney problems					
Heart problems					
Thyroid problems					
Genetic/Autoimmune disorder					
Mental illness					
Other (_____)					

LIFESTYLE

Diet Habits: In general, do you watch what you eat?

Yes

No

Check all dietary issues that apply to you:

☐ Overeating ☐ Sweets/Carbs ☐ Snacking
☐ Large Portions ☐ Sweetened Beverages ☐ Meal Skipping
☐ Dining Out

How would you describe your exercise habits?

☐ None ☐ Mild ☐ Moderate ☐ Intense

Type of exercise

How many days a week?

Duration?

Additional Comments: