SUPPLEMENTAL HEALTH HISTORY QUESTIONNAIRE

Patient Name (First, MI, Last)	**DOB**

Marital Status

☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed

Is there a person who you would like to be your primary contact regarding your healthcare? ☐ Yes ☐ No

If yes, Name: ______________________________ Relationship: ____________ Phone:______________________

Employment History

Occupation (Previous if Retired) ______________________________ ☐ Retired

Employer ______________________________

Medical Evaluation and Procedures

	Date	Comment
Last Primary Care Visit		
Last Dental Exam		
Last Dermatology Exam		
Last Colonoscopy or Sigmoidoscopy		
Last Bone Density (DEXA) scan		
Female Tests		
Last PAP Smear		
Last Mammogram		
Male Tests		
Last PSA		

Activities and Assistance

	Yes	No	Describe
Do you live alone?	☐	☐	
Do you need any assistance for daily activities?	☐	☐	
Do you need any assistance with transportation?	☐	☐	
Do you have family/friends to assist with your needs?	☐	☐	
Do you exercise?	☐	☐	
Religious beliefs you would like us to be aware of:	☐	☐	
Do you have an advance directive?	☐	☐	Please provide a copy

Patient Name (First, MI, Last)	**DOB**

Tobacco Use

- ☐ Never
- ☐ Current Smoker – Every Day
- ☐ Current Smoker – Some Days
- ☐ Former Smoker Years Quit ____________
- ☐ Secondhand Smoke Exposure
- ☐ Cigars or Pipe
- ☐ Chewing Tobacco

Current or Former Smokers:

Number of Packs Per Day ____________ Number of Years ____________

Comments on your history with tobacco:

____

Alcohol Use

- ☐ Never
- ☐ Every Day Number of Drinks Per Day ____________ ____________ Ounces
- ☐ Some Days Number of Drinks Per Week ____________
- ☐ Previous

Comments on your history with alcohol:

____

Recreational Drugs

- ☐ Never
- ☐ Current What Kind? ______________________________
- ☐ Previously

Comments on your history with recreational drugs:

____

Exposure History

Have you ever worked or spent time in an environment which led to exposure to:

- ☐ Chemicals?
- ☐ Radiation?
- ☐ Dust?

Comments on your exposure history:

____