Health History Questionnaire

Patient Information

Name: Mary Jane Espinosa **Date of birth:** 07/15/1985 **Gender:** Female

Address: 123 Main St.

City: San Diego **State:** California **Zip Code:** 92101

Phone Number: 555-1234 **Email:** mary.espinosa@email.com

Emergency Contact Name: John Espinosa

Emergency Contact Number: 555-5678 **Relationship to Emergency Contact:** Husband

Medical History

1. Have you ever been hospitalized? If yes, please provide details.

Yes, when I had my appendix surgery in 2008.

2. Have you had any surgeries? If yes, please provide details.

Yes, I had my appendix removed in 2008.

3. Do you have any allergies? If yes, please provide details.

No, I don't have any allergies.

4. Do you have any chronic medical conditions? If yes, please provide details.

Yes, I have asthma.

5. Do you have a history of mental health conditions? If yes, please provide details.

No, I don't have a history of mental health conditions.

6. Do you have a history of substance abuse? If yes, please provide details.

No, I don't have a history of substance abuse.

7. Do you have a family history of medical conditions? If yes, please provide details.

Yes, my mother has high blood pressure, and my father has diabetes.

Current Medications

Please list all current medications you are taking, including dosage and frequency.

I take albuterol inhaler for asthma as needed.

Immunization History

Are you up-to-date on your vaccinations? If not, please provide details.

Yes, I'm up-to-date on my vaccinations.

Lifestyle Factors

1. Do you smoke? If yes, how many cigarettes per day?

No, I don't smoke.

2. Do you drink alcohol? If yes, how many drinks per week?

Yes, I drink socially, about two drinks per week.

3. Do you use recreational drugs? If yes, please provide details.

No, I don't use recreational drugs.

4. Do you exercise regularly? If yes, please provide details.

Yes, I try to exercise at least 3 times a week by jogging.

5. Do you have a balanced diet? If no, please provide details.

I try to eat a balanced diet, but I sometimes have trouble making healthy choices.

Women's Health (if applicable)

1. Are you pregnant? If yes, how many weeks?

No, I'm not pregnant.

2. Do you use any form of contraception? If yes, please provide details.

Yes, I use birth control pills.

3. Do you have irregular periods? If yes, please provide details.

No, my periods are regular.

4. Have you experienced menopause? If yes, please provide details.

No, I haven't experienced menopause.

Additional Questions

1. Is there anything else you think we should know about your health history?

No, that's all.

2. Is there anything else you would like to discuss with your healthcare provider?

No, I don't have any concerns at this time.