Steven A. Crews, DO, PA, Family Practice 8135 Centralia CT STE 101 Leesburg FL 352-360-0654 SEC FAX 352-360-0668

PERSONAL HEALTH HISTORY QUESTIONNAIRE 2015

ALL PORTIONS of questionnaire SHOULD BE COMPLETELY FILLED out, Put N/A if it does not apply.

Today's Date:	

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**	

Current Medications **(IF PILL BOTTLES ARE BROUGHT TO THE VISIT YOU DO NOT NEED TO COMPLETE THIS SECTION EXCEPT FOR OVER THE COUNTER AND HERBAL MEDICATIONS)**

Name of the Drug (BRAND and Generic)	Strength/dose/form	How and when you take the medications

List any MEDICAL problems that other doctors have diagnosed:

Allergies or intolerance to Medications? Please list the drug and make sure you are specific about your reaction

Name of the Drug (Brand or Generic)	Reaction You Had

Other hospitalizations in last 2 years (add additional information on last page)

Year	Reason	Hospital

List all Surgical Procedures you have had done

FAMILY HEALTH HISTORY (PLEASE COMPLETE TO THE BEST OF YOUR ABILITY)

	BIRTH YEAR *(or age at death)*	HEALTH PROBLEMS		**BIRTH YEAR** *(or age at death)*	HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Siblings	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

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PERSONAL HEALTH HISTORY QUESTIONNAIRE 2015

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL BUT WE MUST ASK THEM AS PART OF OUR MEANINGFUL USE REQUIREMENT AND WILL BE CONFIDENTIAL IN COMPLIANCE WITH PRIVACY POLICIES

Have you had any of the following infections? *if yes circle your answer* Herpes HIV Chlamydia Gonorrhea HPV

Have you ever had a blood transfusion? **If yes, what year:**	☐ Yes	☐ No		
Have you ever had radiation therapy? **If yes, indicate reason:**	☐ Yes	☐ No		
Have you ever had a blood clot in your legs or lungs? **If yes, what year:** **did it go to lung?**	☐ Yes	☐ No		
Have you been tested for HIV?	☐ Yes	☐ No		
Have you been tested for HEP C? IF YES-------what Year? **Result?**	☐ Yes	☐ No		

IMMUNINZATION HISTORY PLEASE COMPLETE WE NEED THIS FOR YOUR HEALTH

Childhood illness:	CHECK any you have had	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
	Vaccination NAME	DATE GIVEN	Vaccination NAME	DATE GIVEN
Please indicate current vaccinations and DATE received	☐ Tetanus or TET/DIP		☐ Pneumonia (Pneumovax PPSV23)	
	☐ Hepatitis*(series of 3)*		☐ Chickenpox/Shingles Shot	
	☐ Influenza		☐ MMR (*Measles, Mumps, Rubella)*	
	☐ HPV		☐ DTaP (new)	
	☐ BCG vaccination		☐ Smallpox	
	☐ Prevnar (PCV13)		☐ Polio	
	NOTES:			

Questions about your wishes.	Do you have an Advance Directive or Living Will? If yes, please furnish a copy for your record.	☐ Yes	☐ No		
	If you do not, would you like information on the preparation of these? If yes, please ask our staff or check our website at crewsfamilypractice.com	☐ Yes	☐ No		
	Have you designated a Healthcare Surrogate? If yes, please furnish a copy of your designation for your records.	☐ Yes	☐ No		
	Are you an organ donor?	☐ Yes	☐ No		

ADDITIONAL INFORMATION YOU THINK MAY BE BENEFICAL FOR US TO KNOW.

Email address for secure patient portal access: _____

May we notify you of appointments at this email address? Yes No

May we notify you of test results at this email address? Yes No

Name of Local Pharmacy Pharmacy Phone Number

Location of Local Pharmacy

Mail Order Pharmacy Mail Order Phone Number

Who Referred you to our office?

Name: DOB