WHITE-WILSON
MEDICAL CENTER, P.A.

WWMC HEALTH HISTORY QUESTIONNAIRE

NAME: _____ DATE: _____

Date of Birth:_____ M/F ____ Preferred Language_____ Race_____

Significant Illnesses

Do you have or have you had any of the below (circle)

Diabetes	Yes	No
Cancer	Yes	No
High Cholesterol	Yes	No
High Blood Pressure	Yes	No
Heart Disease	Yes	No
Kidney Disease	Yes	No
Mental Illness	Yes	No
Abnormal Pap	Yes	No
Asthma	Yes	No
Gout	Yes	No

Other Illness not listed: _____

_____

FAMILY MEDICAL HISTORY

Has any blood relative, including children, had any of the following:

			Relationship
Anemia	Y	N	_____
Bleeding Tendency	Y	N	_____
Cancer	Y	N	_____
Diabetes	Y	N	_____
Epilepsy	Y	N	_____
Heart Disease	Y	N	_____
High Cholesterol	Y	N	_____
Stroke	Y	N	_____
Tuberculosis	Y	N	_____
Colon Polyps	Y	N	_____

SOCIAL HISTORY

Tobacco History	Y	N	# years _____
Alcohol	Y	N	Drinks per week _____
Caffeine	Y	N	Cups/cans per week _____
Recreational Drugs	Y	N	Times per week _____
Exercise	Y	N	Times per week _____

HOSPITALIZATIONS / SURGERIES

List all reasons you were hospitalized	Year
1 _____	
2 _____	
3 _____	
4 _____	
5 _____	

HEALTH SCREENING

Have you had			Date of Last
Physical	Y	N	_____
Pap	Y	N	_____
Colonoscopy	Y	N	_____
Chest X-ray	Y	N	_____
Mammogram	Y	N	_____
Bone Density	Y	N	_____
EKG	Y	N	_____
Tetanus shot	Y	N	_____
MMR shot	Y	N	_____
TB test	Y	N	_____
Hepatitis vaccine	Y	N	_____
Pneumonia shot	Y	N	_____
Shingles Vaccine	Y	N	_____

ALL ALLERGIES

Medications/Foods/ETC	REACTION
1 _____	
2 _____	
3 _____	
4 _____	

MEDICATIONS

1 _____ 6 _____

2 _____ 7 _____

3 _____ 8 _____

4 _____ 9 _____

5 _____ 10 _____

Your Pharmacy _____ Location _____

example CVS Beal and Green Acres

Are you having any pain? Yes No

Is it new pain? Yes No

Do you have chronic pain (everyday)? in Yes No

How bad is the pain? Aching ____Burning __Dull __Pressure Sharp __ Shooting __ _____

Squeezing _____Stabbing __Throbbing Other __

Please circle anything the pain affects: sleep energy appetite activity mood work relationships _____

Are you currently taking anything for pain? Yes No

Are you or have you been in a relationship in which you feel unsafe? Yes No

Have you or your children been hit or threatened? Yes No

Have you fallen in the last 3 months? Yes No

Do you have difficulty walking? Yes No

Do you have problems with imbalance? Yes No

Do you have:

Living Will Yes No

DNR (Do Not Resuscitate) Yes No