Mahwah Medical

Health History Questionnaire (age 10 and up)

Patient Name: _____ DOB: _____

Reason for today's visit:

_____.

Personal Medical Problems □ None known

Have you ever been treated for depression, anxiety or any other mental health problem? Yes □ No □

Surgeries: □ None

Type of Surgery & Date:_____ Type of Surgery & Date:_____.
Type of Surgery & Date:_____ Type of Surgery & Date:_____.
Type of Surgery & Date:_____ Type of Surgery & Date:_____.

Non-surgical hospitalizations: (please include Date and Hospital): □ None

_____.
_____.
_____.

Medications: (list all medications, including Over the Counter) – include Dose and Frequency □ None

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Pharmacy Name: _____ Phone number: _____

Allergies: (include reaction): □ none known

_____
_____

Social History:

Tobacco use: Yes □ No □ Cigarettes or Pipe _____ packs/day for _____ years. □Quit Date: _____
Smokeless Tobacco use: Yes □ No □ _____ packs/cans per day for _____ years. □Quit Date: _____
Alcohol use: How many drinks per day? _____ Week? _____ Month? _____
What kind of Alcohol? Beer, Wine, Liquor

Have you ever or do you now use illegal drugs? Yes □ No □ Which? _____

Exercise: □ No Exercise □ Mild Exercise □ Occasional, less than 4x/week □ Regular vigorous
Caffeine: □ None _____ cups/cans per day
Are you currently trying to lose weight? Yes □ No □ Are you happy with your weight? Yes □ No □

Women Only:

Age at onset of menstruation: _____ Date of last menstrual period: _____
Pregnancies: _____ # Live births: _____ # Living children _____
Miscarriages/Abortions: _____ # Vaginal births: _____ # C-sections: _____

Updated 3/2019