ANNUAL UPDATE *Date:*_____*Name:*_____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*	**DOB:**
Pharmacy Name and Phone Number: **Address (please provide at least the street and city if known):**	
Primary Care Physician:	**Phone Number:**

HEALTH HISTORY UPDATE

List all current prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:

Drug Name: Strength: Frequency Taken:	Drug Name: Strength: Frequency Taken:

Allergies to medications:

Name of drug:	Reaction you experienced:

Do you have a LATEX allergy: If yes, what was your reaction:

Do you have an adhesive allergy (for example, band aids or tape):

Do you have any food allergies:

List any NEW Surgeries you have had SINCE YOUR LAST VISIT with Dr. Hagerty:

Date	Reason Performed Surgery Performed	Hospital

List any NEW Significant Illnesses, Medical problems or Hospitalizations you have had SINCE YOUR LAST VISIT with Dr. Hagerty:

Date	Medical Problem/Illness/Testing (Result/Diagnosis)	Hospital

Has anyone in your FAMILY been diagnosed with **cancer** SINCE YOUR LAST VISIT with Dr. Hagerty? YES NO
If YES, who/type of cancer/age of diagnosis/cause of death?

List any other changes to your FAMILY HISTORY since your last visit with Dr. Hagerty:

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind and how many Drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks/day		☐ Chew - #/day	☐ Pipe - #/day		☐ Cigars - #/day
	☐ # of years	☐ Or year quit:				
Drugs	Do you currently or have you ever use recreational or street drugs?				☐ Yes	☐ No
	If so, what drug(s)? Last Use:				☐ Yes	☐ No
Sex	Do you currently have a sexual partner? (If you desire, please indicate: male, female, or both)				☐ Yes	☐ No
	Date of the first day of your last period: (if applicable) ____/____/____					
	If you are trying to prevent pregnancy, what method are you using?					
	Physical, sexual and/or mental abuse have also become major public health issues in this country. Do you feel safe at home and work?				☐ Yes	☐ No