Amherst Medical Associates Health Questionnaire

Please complete this questionnaire so that we can serve your health needs. NOTE: This is confidential information that will not be released to any person except when you have authorized us to do so. Please use backside if you need more space.

Name:	Age:	Date of Birth:	☐ Single ☐ Divorced ☐ Widowed ☐ Married
Date of last Physical Examination:	Birthplace:		Today's Date:

Occupation:	Past Surgeries/Hospitalizations *(Give Details – Dates and Reasons)*
List all medications, dose and frequency presently being taken *(include birth control pills and vitamins)* 1 2 3 4 5 6 7	

What kind of special diet do you follow?	Date of last Tetanus:	Allergies
		☐ Penicillin ☐ Bees / Wasps ☐ Sulfa ☐ Codeine/Morphine ☐ Mycin ☐ Tetanus Antitoxins ☐ Asprin ☐ Food/ Other

Past Medical History / Review of Symptoms *(please check all that apply)*

☐ AIDS / HIV	☐ Cancer	☐ Frequent infections or boils	☐ High or Low Blood Pressure	☐ Pleunsy
☐ Anema or any Bleeding Disorder	☐ Chicken Pox	☐ Gallbladder Disease	☐ Hives or Ecxema	☐ Pneumonia
☐ Any bone or joint disease	☐ Colitis or other bowel disease	☐ German Measles	☐ Influenza (flu)	☐ Polio or Meningitis
☐ Appendicitis	☐ Contussion	☐ Glaucoma/Cataracts	☐ Lacerations	☐ Rheumatic Fever
☐ Arthrisis or Rheumatism	☐ Diabetes	☐ Gonorhea, Syphilis or any other STD	☐ Measles	☐ Scarlet Fever or Scariatina
☐ Asthma	☐ Diptheria	☐ Gout	☐ Migraine Headaches	☐ Skin Disease (specify in "other")
☐ Bladder or Urinary Tract Disease	☐ Dislocations	☐ Hayfever	☐ Mumps	☐ Small Pox
☐ Broken or Cracked Bones	☐ Emphysema	☐ Heart Disease	☐ Nephritis or any other Kidney disease	☐ Sprains or Strains
☐ Broncitis	☐ Epilepsy/Seizures	☐ Hemorrhoids or any rectal disease	☐ Nervous or any Psychiatric Disorder	☐ Whooping Cough
☐ Bursitis, Sciatica or Lumbago	☐ Food, Chemical or Drug Poisoning	☐ Hepatitis or Jaundice	☐ Neuritis or Neuralgia	☐ Tuberlocus
☐ Other (please specify below)				

Social History *(please check all that apply)*

Have you ever smoked?	☐ Yes ☐ No
How many packs per day?	
For how many years?	
Do you drink alcohol?	☐ Yes ☐ No
How much per day?	
Have you ever taken recreational drugs?	☐ Yes ☐ No
Are you Sexually Active?	☐ Yes ☐ No
Type of Birth Control Used:	
Have you ever been abused?	☐ Yes ☐ No
If yes, when?	
How old were you when your periods started?	
How Many: Pregnancies	
Abortions Miscarriages	
Date of your last Period:	
Date of your last Pap Smear:	
Date of your last Mamogram	
Who is your Gynocologist?	

Family History: Has anyone in your family *(blood relatives)* had any of these conditions?

☐ Alcoholism	☐ Cancer	☐ High Blood Pressure	☐ Psychiatric
☐ Arthritis	☐ Epilepsy / Seizures	☐ Kidney Problems	☐ Skin Problems
☐ Bleeding Problems	☐ Heart Problems	☐ Lung Problems	☐ Stroke
☐ Bowel Problems	☐ Diabetes	☐ Obesity	☐ Tuberculosis

	Name	Age	Living – Medical Problems	Deceased – Cause of Death
Mother				
Father				
Siblings				
Children				