Amherst Medical Associates Health Questionnaire

Name: _____ Date: _____

Date of birth: _____ Age: _____

NOTE: This is confidential information. We will not release it to any person, except when you have authorized us to do so. Please use the backside of this form if you need additional space.

Have you completed Advanced Directives or a Healthcare Proxy? (*Circle*) No / Yes

IF ANSWERED YES, PLEASE BRING A COPY TO YOUR INITIAL APPOINTMENT

Medications: (*list all medications you are taking regularly. Include over the counter, birth control, vitamins, herbal, or natural remedies.*)

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

PLEASE BRING CURRENT MEDICATION BOTTLES TO YOUR INITIAL APPOINTMENT

Allergies: Are you allergic to anything? (*Circle*) No / Yes * If answered yes, please list:

_____
_____

PLEASE BRING A CURRENT LIST OF YOUR VACCINATIONS TO YOUR INITIAL APPOINTMENT

Medical illnesses or Conditions: (*list any chronic conditions in which you are diagnosed with***)**

_____
_____
_____
_____
_____

Social History (*check all that apply*)

Have you ever smoked? _____
How many packs per day? _____
For how many years? _____
Do you drink alcohol? _____
How many drinks per day? _____
Do you exercise? _____ How many days per week?_____
What type of exercise? _____
Have you ever taken recreational drugs? _____
Are you sexually active? _____
Have you ever been abused? _____
What kind of special diet do you follow? _____
_____
_____
_____

Specialists: (*names of specialists you're currently seeing)*

Family History: Has anyone in your family had any of these conditions?

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

	Name	Age	Living/ medical problems	Deceased/cause of death
Mother				
Father				
Siblings				
Children				