ROIS MEDICAL GROUP
HEALTH & WELLNESS

HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First):*		☐ M ☐ F	**DOB:**
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:			**Date of last physical exam:**
Preferred Pharmacy:			
Preferred Laboratory:			

PERSONAL HEALTH HISTORY

Immunizations and dates:	☐Tetanus/Tdap	☐ COVID	☐ Pneumovax 23 ☐ Prevnar 13
	☐ Hepatitis B	☐ Shingles	☐ Chickenpox
	☐ Influenza		☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

☐ Hypertension	☐ Hyperlipidemia	☐ Coronary artery Disease
☐ Diabetes Mellitus Type __	☐ Sleep Apnea	☐ Stroke
☐ Hypothyroidism	☐ COPD	☐ Reflux disease
☐ Chronic Kidney Disease	☐ Asthma	☐ Other _____

Surgeries

Year	**Reason**		
	☐ Cholecystectomy	☐ Hysterectomy	Others:
	☐ Appendectomy	☐ Heart Surgery	
	☐ Hip replacement	☐ Bariatric Surgery	
	☐ Knee replacement	☐ Mastectomy	

Have you ever had a blood transfusion?	☐ Yes	☐ No
Are you a Jehovah witness?	☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Yes ☐ No if so days a week _____					
Caffeine	☐ Yes	☐ No	# of cups/cans per day?			
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	How many drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	If yes, please list:					

RELEVANT FAMILY HEALTH HISTORY		
	Age	Significant Health Problem
Father		
Mother		
Sons		
Daughters		