



HEALTH HISTORY QUESTIONNAIRE

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

Name: <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Living Conditions: <input type="checkbox"/> Alone <input type="checkbox"/> With Family <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Assisted Living <input type="checkbox"/> Skilled nursing facility			
Referring doctor:		Date of last physical exam:	
Home Health Agency:		Pharmacy:	Number:

PERSONAL HEALTH HISTORY

Medical History		
Year	Diagnoses	

Surgeries		
Year	Type of Surgery	Hospital

Hospitalizations		
Year	Reason	Hospital



Please list any medications you are currently taking or attach a list

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction to Medication	Onset Date

PERINENT MEDICAL HISTORY

Major Injuries	<input type="checkbox"/> Please list, date, and describe any major injuries:		
Diagnostic Testing	Type of Testing:	Date:	Results:
	Chest x-ray		
	EKG		
	MRI (Location): _____		
	CT Scan (Location): _____		
	EEG		
	SPECT Scan		
	PFT		
	Other: _____		
Therapies	Type of Therapy:	Date & Length of Therapy	Progression?



SOCIAL HISTORY

Alcohol	How often did you have a drink containing alcohol in the past year?		
	<input type="checkbox"/> Never <input type="checkbox"/> Monthly or less <input type="checkbox"/> 2-4 times a month <input type="checkbox"/> Two to three times per week <input type="checkbox"/> four or more times a week		
Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Smoke Cigarettes – # packs/day:
	Former Smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> # of years
	<input type="checkbox"/> Year quit		
Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Have you had a fall within the last 3 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you wear hearing aids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you wear glasses or contacts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, do you have a copy to provide for RegenQuest	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		