**ALTA CALIFORNIA MEDICAL GROUP, INC.**
**CURRENT HEALTH STATUS**
**QUESTIONNAIRE**

Name:________________________________Date:____________________MRN:______________

**Current Medications**: (including non-prescription) with strengths and frequencies
1)_________________________ 2)_______________________ 3)____________________________
4)_________________________ 5)_______________________ 6)____________________________
**Allergies**: (describe reaction)___________________________________________________________
**Hospitalizations/Surgeries**: Reason for hosp/surg and approx. year (include childhood)
1)_________________________ 2)_______________________ 3)____________________________
4)_________________________ 5)_______________________ 6)____________________________

**Your Past Illnesses** (check if you have now or have had in the past)

| | | | | |
|---|---|---|---|---|
| __Asthma | __Severe Headache | __Visual Problems | __Thyroid Disease | __Lung Disease |
| __Heart Disease | __Phlebitis (Blood Clot) | __High Cholesterol | __Stomach Ulcer | __Diabetes |
| __Kidney Disease | __Bleeding Problems | __Severe Depression | __Transfusions | __Anemia |
| __Seizures | __Pelvic Inflam Dis. (PID) | __High Blood Pressure | __Stroke | __Alcoholism |
| __Drug Abuse | __Gallbladder Disease | __Liver Disease | __AIDS | __Cancer |

**Other Major Medical Problems (list):**__________________________________________________

**Family Illnesses:** Please list any of the above diseases your family members have or have had.

| | Living / Deceased? | Age now or at death | Disease/Condition |
|---|---|---|---|
| Father | ___________________ | ________________ | ___________________________________ |
| Mother | ___________________ | ________________ | ___________________________________ |
| Brother/Sister | ___________________ | ________________ | ___________________________________ |
| Brother/Sister | ___________________ | ________________ | ___________________________________ |
| Other Family | ___________________ | ________________ | ___________________________________ |
| Other Diseases? | ___________________ | ________________ | ___________________________________ |

**Your Health Habits:** Ever smoke? Yes / No Packs/day____ How long? _____ Do you smoke now? Yes / No
Alcohol (drinks per week on average)_________ Do you chew tobacco? Yes / No
Have you ever used any street or recreational drugs or pills? Yes / No

**Social History:** What is your current occupation?____________________________________________

**Please list your household members**:_________________________________________________

**Preventive Medicine –** please answer every question as best you can. [Write D/K (don't know) if necessary]
Do you always wear your seat belts?…………………………………………………………………………Yes / No
When was your last tetanus booster?…………………………………………………………………...._____________
When was your last cholesterol blood test?……………………………………………………………._____________
Have you ever been immunized against pneumonia?………………Yes / No.... if yes approximate yr. ___________
Have you had a flu shot this year?…………………………………………………………………………..Yes / No
When did you last have a test for blood in the stool? (if you've had one)………………………………_____________
Have you ever had a colonoscopy?..............................................Yes / No…..if yes approximate yr..___________
**MEN**
When was your last rectal exam?…………………………………………………………._________
**WOMEN**
When was your last Pap smear?…………………………………………………………...._________
When was your last mammogram? (if you've had one)……………………………………..._________
# of Pregnancies ____________ # of Deliveries ________ # of Miscarriages ____________
# of Abortions _____________ # of C-Sections _______ Date of last preg. ____________
Current Contraceptive Method_________________________________________________________

Patient's Signature______________________________ Provider Signature________________MD/NP/PA
Date___________________________________ Date__________________________________________