VIPMD HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First, M.I.):* ☐ M ☐ F	DOB:	Today's Date:

As a courtesy we will offer to electronically fax prescriptions (if any) to your pharmacy, please indicate which pharmacy you prefer and the cross streets so that we may accurately identify it during this process: _____

PERSONAL HEALTH HISTORY

Immunizations: ☐ Tetanus: Year_____ Tdap or Td? _____ ☐ Influenza: Year _____ ☐ Pneumonia: Year_____

List all past medical problems such as high blood pressure, diabetes, bronchitis, sleep apnea, etc.

☐ NONE			

List surgeries such as gallbladder removal, appendectomy, heart surgeries, back surgeries, etc. and the year of the surgery

☐ NONE			

List all medications currently being used including prescribed, OTC meds, supplements and oxygen

Name of Medication/Reason for Medication	Strength	How Often?	Name of Medication/Reason for Medication	Strength	How Often?
☐ NONE					

Allergies to *Medications*, *Foods* and/or *Environment*

Name of Medication/Allergen	Reaction You Had	Name of Medication/Allergen	Reaction You Had
☐ NONE			

The information provided will be entered into our electronic medical record. For your safety please be complete and accurate to the best of your ability. If you have of these forms within the last year please let our front desk know and we will pull it up for you to verify.

<u>*If you are experiencing chest pain or shortness of breath please alert front desk staff immediately*</u>

Initials:_____ **Date:**_____ **Initials:**_____ **Date:**_____

Initials:_____ **Date:**_____ **Initials:**_____ **Date:**_____

Initials:_____ **Date:**_____ **Initials:**_____ **Date:**_____