Eureka Family Practice
Medical Questionnaire

Dates reviewed

NAME _____ **Date of Birth** _____

Active Chronic Problems:

Prescriptions – including strength and dosages please. Write on back if necessary

Non-prescription (aspirin, herbs, vitamins, etc.)

Drug Allergies:

Other Allergies

Preferred Pharmacy:

Past Medical History

Medical Problems

Surgical History (include year)

Hospitalizations not listed above (include year)

Colon Cancer Screening YES NO DATE_____

Transfusions YES NO DATE _____

Cholesterol Check (Lipid Panel) YES NO DATE _____

Tetanus vaccine or dTap vaccine (circle one) DATE _____

Date of last Flu Vaccine _____

Date of Pneumonia Vaccine_____

Teens: Meningococcal YES NO Date_____

HPV Vaccine YES NO Date_____

***children – please bring immunization records with you to first visit**

-OVER-

Family History	Age	Medical Problems	If Deceased cause of death
Mother			
Father			
Siblings			
Children			
Other			

Social History

What type of work do/did you do?

Please circle one: single married divorced widowed domestic partner male female

Tobacco history

Ever smoked or chewed: yes no
Year started:
Year quit:
Packs per day:

Do you drink alcohol: yes no
How much:

Have you every had a substance abuse problem: yes no

Do you exercise: yes no
If yes, what do you do?

Women Only: Gynecologic History

Number of pregnancies: Live Births: Miscarriages: Abortions: C-Sections:

When was your last pap smear:_____ When was your last mammogram:_____

Have you ever had an abnormal pap smear?_____Hysterectomy? YES NO

How old were you when you started having periods:_____

If your period has stopped, how old were you when that happened:_____

If still having periods:

Date last period started:_____

Are your periods regular: yes no

How long do they last:_____

How often do they occur:_____

Patient Reminder Preference ☐ Letter ☐ Phone ☐ Electronic