SACO RIVER MEDICAL GROUP

HEALTH HISTORY QUESTIONNAIRE

THIS QUESTIONNAIRE IS VERY IMPORTANT TO YOUR HEALTH. WE RELY ON YOUR RESPONSES WHEN TREATING YOU. PLEASE TAKE THE TIME TO PROVIDE THIS INFORMATION COMPLETELY AND ACCURATELY.

NAME:	**DATE OF BIRTH:**

REASON FOR THE VISIT

PLEASE LIST 3 MAIN REASONS FOR TODAYS VISIT

1. _____
2. _____
3. _____

CURRENT MEDICATION LIST

PLEASE INCLUDE PRESCRIPTION MEDICATIONS, OVER-THE-COUNTER MEDICATIONS, HERBAL SUPPLEMENTS, ETC. CORRECT DOESING, FREQUENCY AND THE STARTING DATE.

NAME OF MEDICATION	STRENGTH/DOSE	FORM (CAP/TAB)	FREQUENCY (HOW OFTEN)	STARTING DATE

PLEASE LIST ANY ADDITIONAL MEDICATIONS ON THE REVERSE SIDE OF THIS FORM

Conway Office: (603) 447-3500 **Glen Office**: (603) 383-3005 **Fax**: (603) 447-5568

NAME:		DATE OF BIRTH:	

PAST MEDICAL HISTORY

PLEASE LIST ALL YOUR MEDICAL PROBLEMS THAT YOU HAVE NOW AND HAVE HAD IN THE PAST. LIST IF THEY ARE ACTIVE OR NOT AND THE YEAR IN WHICH EACH CONDITION STARTED. (Diabetes, High Blood Pressure, Heart Disease, Thyroid Problems, etc.)

MEDICAL CONDITION	CURRENT/PAST	YEAR STARTED	STATUS

ALLERGIES

PLEASE LIST ANY ALLERGIES YOU MAY HAVE (Medications, Food, Latex, Beestings, Dust, Pollen, etc.) TYPE OF ALLERGY (Rash, Difficulty Breathing, etc.)

SUBSTANCE	TYPE OF ALLERGY

NAME:	**DATE OF BIRTH:**

HOSPITALIZATIONS/SURGERIES/PROCEDURES

LIST THE DATE, REASON FOR ABOVE AND OUT COME

DATE	**REASON**	**OUTCOME**

FAMILY HISTORY

PLEASE LIST ANY OF THE BELOW CONDITIONS THAT YOUR FAMILY MEMBERS MAY HAVE

	MOTHER	**FATHER**	**SISTER**	**BROTHER**	**GRANDMOTHER (Maternal/Paternal)**	**GRANDFATHER (Maternal/Paternal)**
High Blood Pressure						
MI/Cardiac Disease						
High Cholesterol						
Diabetes						
Cancer						
Stroke						
Thyroid						
Mental Health						
Alcohol/ Addiction						
Alzheimer's						
Blood Clots						
Osteoporosis						
Other:						

NAME:	DATE OF BIRTH:

SIGNATURES

PLEASE SIGN BELOW. By doing so, you are certifying that the responses in this questionnaire are complete and accurate to the best of your knowledge.

PATIENT SIGNATURE: _____ DATE: _____

If the patient is unable to sign, provide reason: _____

If you are not the patient, but you completed this questionnaire for the patient, please sign below. By doing so, you are certifying that the responses in this questionnaire are complete and accurate to the best of your knowledge.

SIGNATURE OF PERSON SIGNING THIS QUESTIONNAIRE: _____
(Only if different than patient)

PRINT YOUR NAME: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____