INFECTIOUS DISEASE CONSULTANTS

HEALTH HISTORY

Welcome to Infectious Disease Consultants. So that we can get to know you better and help you with any problems you may have, complete this health questionnaire to your best understanding. If you are not sure, mark the question with a question mark and we will discuss it with you at your appointment.

NAME: _____
Date of birth: __/__/____ Age: _____ Height: _____ Weight: _____

Who is your primary care provider? Name: _____
Phone Number: _____

Who referred you to our office? Name_____
(If different from the previous one) # Phone: _____

What is your preferred pharmacy? Name: _____
Address: _____
Phone #: _____

If we try to contact you, can we leave a message (including information related to your diagnosis) on your answering machine/answering machine?

□ Not □ Yes, preferred number: (___) _____-_____

How would you like to receive medical records/lab results?

____ Home address: _____

____ Phone Number: (___) ___- _____
____ Email: _____
IF □ □ NOT email the actual medical records (there are confidentiality risks in electronic communications).

In your own words, why are you here to see an infectious disease doctor?
_____
_____
_____
_____

What medications are you currently taking (including vitamins, herbs, etc.)? You can write on the back of the paper if you need additional space.

Name of the medicine	Dosage taken	How often	For what purpose (Diagnosis)

Have you ever had drug allergies? If □ No □

Name of the medicine	Reaction

Please list all your medical problems (hypertension, diabetes, etc.)

Are you pregnant? Yes □ No □ Are you currently trying to get pregnant? Yes □ No □

Medical Problem	When was he diagnosed?

Please list all your surgeries and hospitalizations

Surgeries/ Hospitalizations	Dates (approx.)	Where treated

Have you had these vaccines?

Vaccine	Last date of the vaccine	Vaccine	Last date of the vaccine
Pneumovax/Prevnar 13		Hepatitis A	
Influenza		Hepatitis B	
Tetanus (TDAP)		Chicken Pox/Shingles	

Who do you live with? _____

Who knows about your condition? _____

Where have you lived before? _____

Marital status: Single □ Married □ Partner □ Widower
Are you working? □No □ If yes, what is/was your occupation? _____

Substance use

Do you smoke cigarettes? Never □ I no longer use □ Resign _____ Yes □ Average _____ cigs/day
How old were you when you started smoking? _____
Do you drink alcohol? Never □ I no longer use □ Quit _____ Yes □ Average _____ drinks / day
Do you drink caffeinated products? Yes □ No □ If so, Average _____ drinks / day
Have you ever injected intravenous drugs? Yes □ No □
Have you ever used illicit drugs (i.e. cocaine, etc.)? Yes □ No □ If so, what? _____

Family history

Have any of your blood relatives had any of the following?

Medical condition	If applicable (✔)	Which family member does this apply to? Approx. Age?
High pressure		
Heart disease, myocardial infarction		
Hyperlipidemia (high cholesterol)		
Heart attack		
Diabetes		
Cancer		
Kidney disease, dialysis		
Alzheimer's disease		
Autoimmune disease (lupus, thyroid dis. Rheumatoid arthritis, etc.)		
Other		

STD History: Yes □ No □
Have you had any of the following? If so, when were you treated?

Syphilis		Herpes simplex	
Gonorrhea		PID	
Chlamydia		Genital warts	

Is there anything else we need to know?

_____
_____