Benacare Medical Center, Inc.
HISTORY & PHYSICAL QUESTIONNAIRE

TODAY'S DATE
/ /

Please answer the following questions prior to your first examination. It will help your physician to know not only about your health, but also about your family and relatives.

NAME:			PHONE NUMBER:
DATE OF BIRTH:	AGE:	PLACE OF BIRTH:	NATIONALITY OF PARENTS:

MARITAL STATUS:
☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ MARRIED - Presently how many years _____

OCCUPATION:	HOW LONG?

CHECK ANY ILLNESS OR CONDITIONS YOU HAVE HAD:
☐ DIABETES ☐ STROKE ☐ HYPERTENSION (High Blood Pressure) ☐ HEART DISEASE ☐ KIDNEY DISEASE ☐ MENTAL ILLNESS (Depression/Anxiety)
☐ BLEEDING TENDENCY ☐ TUBERCULOSIS ☐ DRUG and/or ALCOHOL ADDICTION ☐ HIGH CHOLESTEROL ☐ ARTHRITIS ☐ CANCER ☐ HEPATITIS

PLEASE NOTE ANY OTHERS NOT LISTED ABOVE:

CHECK WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES:
☐ DIABETES ☐ STROKE ☐ HYPERTENSION (High Blood Pressure) ☐ HEART DISEASE ☐ KIDNEY DISEASE ☐ MENTAL ILLNESS (Depression/Anxiety)
☐ BLEEDING TENDENCY ☐ TUBERCULOSIS ☐ DRUG and/or ALCOHOL ADDICTION ☐ HIGH CHOLESTEROL ☐ ARTHRITIS ☐ CANCER ☐ HEPATITIS

PLEASE NOTE ANY OTHERS NOT LISTED ABOVE:

HAVE YOU HAD SERIOUS INJURIES, BROKEN BONES, ETC.?
☐ NO ☐ YES LIST:

HAVE YOU HAD ALLERGY OR SENSITIVITY TO MEDICINE OR OTHER SUBSTANCE?
☐ NO ☐ YES LIST:

DO YOU USE TOBACCO? ☐ NO ☐ YES	IN THE PAST? ☐ NO ☐ YES	TYPE:	DAILY AMOUNT:	HOW LONG:
DO YOU CONSUME ALCOHOL? ☐ NO ☐ YES		TYPE:	WEEKLY AMOUNT:	HOW LONG:

CHECK THE DISEASES AGAINST WHICH YOU HAVE BEEN IMMUNIZED:
☐ SMALL POX ☐ TYPHOID ☐ POLIO ☐ INFLUENZA ☐ PNEUMONIA (Pneumovax) ☐ HEPATITIS A ☐ HEPATITIS B
☐ HERPES ZOSTER (Zostavax) ☐ HUMAN PAPILLOMA VIRUS (Gardisil) ☐ TETANUS - _____/_____ (MO / YR) ☐ OTHER_____

PREVIOUS OPERATIONS:	DATE:

MEDICATIONS:	DOSE:	DAILY AMOUNT:

DENTAL (List any problems you have now):

ONSET OF LAST MENSTRUAL PERIOD:	**PERIODS ARE:** ☐ REGULAR ☐ IRREGULAR	**# OF PREGNANCIES:**	**# OF MISCARRIAGES:**
ORAL CONTRACEPTION? ☐ NO ☐ YES	TYPE:		
HAVE YOU TAKEN CORTISONE TYPE DRUGS? ☐ NO ☐ YES	TYPE:		
HAVE YOU HAD A BLOOD TRANSFUSION? ☐ NO ☐ YES	IF YES, DATE:		
DRESSED WEIGHT:	HOW LONG HAVE YOU BEEN AT THIS WEIGHT?		

REASON BEING SEEN TODAY?

X

SIGNATURE (Patient or Other Legally Authorized Person) RELATIONSHIP TO PATIENT DATE