PATIENT HISTORY QUESTIONNAIRE

Western Washington Medical Group

PATIENT NAME: _____ **DATE OF BIRTH:** _____

REASON FOR VISIT/CURRENT COMPLAINT

DR'S NOTES (DO NOT WRITE IN THIS SPACE)

Please list any medical problems and date they were diagnosed			
Medical Problems	Year	Previous Surgeries and Hospitalizations	Year

Please list all current medications (may provide a separate list):					
Medication	Dosage	Frequency	Medication	Dosage	Frequency

Please list any medications you are allergic to and what happens when you take them.

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SOCIAL HISTORY:
Do you smoke? ❑ Yes ❑ No If Yes, Have you ever smoked? ❑ Yes ❑ No Start: Quit: Packs Per Day:
Do you drink alcoholic beverages? ❑ Yes ❑ No If yes, how often?
Please indicate your marital status: ❑ Married. How Long? _____ ❑ Single ❑ Divorced/Separated ❑ Widowed. How Long? _____
Do you have any children? ❑ Yes ❑ No If yes, how many?

OCCUPATION: Please indicate below the type of work you have done, approximate number of years involved in each occupation.

FAMILY HISTORY: Please comment of health of relatives. (Are they living? Do they have any medical problems? If deceased, please write cause and age at time of death.)
Mother:
Father:
Brothers:
Sisters:

HOBBIES: Please list below any particular hobbies you pursue?

NOTICE: *We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes us or compels us to do so.To see your record or get more information about it inquire at our front desk.*