Dr. Jennifer Madden's Family Practice 3 Northern Blvd, Suite 3A Amherst, New Hampshire 03031 Tel: 603 769-3308 Fax: 603 769-3381	**Your Appointment Information:**	
	Date:	Check-in Time:
Please Complete & Return		

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, MI)*		☐ M ☐ F	**DOB:**
Address:			
City/State	**Zip Code**	**Tel:**	
Name of Employer:			
Address			
City/State	**Zip Code**	**Tel:**	
Occupation:			
Marital Status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Sexuality:	☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transgendered ☐ Other	**Preferred Name:**	
Sexually Active:	☐ Yes ☐ No **Active With:** ☐ Men ☐ Women ☐ Both		
Previous/Referring MD:	**Date of Last Physical Exam:**		
Pharmacy Name/Address/Tel. No:			

PERSONAL HEALTH HISTORY				
Immunization & Dates:	☐ **Tetanus**	**Date:**	☐ **Pneumonia**	**Date:**
	☐ **Hepatitis**	**Date:**	☐ **Chickenpox**	**Date:**
	☐ **Influenza**	**Date:**	☐ **MMR** *Measles, Mumps, Rubella*	**Date:**
List any current medical problems:				

List any past medical problems:

List any surgeries or hospitalizations:
Year:

List any allergies that you have to medication or food:	Reaction:

List prescribed medications and over-the-counter vitamins or supplements:

Medication:	Dose:	Frequency: (how many times per day)

HEALTH HABITS AND PERSONAL SAFETY		
Do you smoke? ☐ No ☐ Yes, how many per day?	**Do you drink alcohol?** ☐ No ☐ Yes, how much per week?	**Do you wear seat belts?** ☐ No ☐ Yes
Are you a vegetarian? ☐ No ☐ Yes	**Do you or have you used illicit drugs?** ☐ No ☐ Yes, which ones?	

FAMILY MEDICAL HISTORY			
Family Member	**Living or Deceased**	**Age**	**Health Issue(s)**
Mother			
Father			
Brother(s):			
Sister(s):			
Children:			