Family Health Center of Ashland City, 342 Frey Street, Ashland City, TN 37015, 615-792-1199
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HEALTH QUESTIONNAIRE For Patient Name: _____Birthdate: _____

Information is self-reported by patient (parent). Answer questions for the person who is getting services today.

Marital status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced
Highest Grade Completed: _____ College: _____
Tobacco Use: ☐Smoke Cigs/Day: _____ ☐Past Smoker Date Stopped: _____
☐Chew/Dip Frequency: _____☐Past Chew/Dip Date Stopped: _____
Substance Abuse: ☐Alcohol Amount/Frequency: _____
☐Drugs (Street/IV) Amount/Frequency: _____
Vaccine History: Last Tetanus _____Flu vaccine _____ Pneumo vac _____
Allergies: _____
☐Wear seat belt/car seat ☐Smoke detector ☐Regular exercise ☐Guns unloaded and out of kids reach
What is your occupation? _____

Your Medical History (Please check all that apply)

☐Anemia ☐Diabetes ☐HIV/AIDS ☐ Sexually Transmitted Disease
☐Arthritis ☐Epilepsy/Seizures ☐Kidney/Bladder ☐ Sexual Problems
☐Asthma ☐Hearing Impaired ☐Liver Disease/Hepatitis ☐Skin Problem
☐Blood Clots ☐Gallbladder Disease ☐Mental Illness ☐ Childhood Diseases
☐Colon/Bowel ☐Heart Disease/Attack ☐Migraine Headaches ☐Tuberculosis
☐Stroke ☐High Blood Pressure ☐Depression ☐Vision Problems (cataracts, glaucoma)

Any other medical problems: _____
Hospitalizations: _____
Surgeries: _____

When was your last complete check-up (physical exam, blood tests)? _____
If you were born after 1957, have you had a second measles, mumps and rubella vaccination? ☐yes ☐no ☐don't know

Family Medical History of Patient (Include parents, grandparents, brothers, sisters)

	Father	Mother	Father Parent	Mother Parent	Brother Sister		Father	Mother	Father Parent	Mother Parent	Brother Sister
Cancer						Kidney Disease					
Diabetes						Glaucoma					
Heart Disease						Bleeding disorders					
Stroke						Mental Illness					
High blood Pressure						Epilepsy/Seizures					
Other											

Advance Directives For Health Care (If the patient is over 18)

Have you finalized any advanced health directives (examples- living will, durable power of attorney for healthcare, organ donation, "do not resuscitate" instructions)? ☐yes ☐no
If not, would you like information? ☐yes ☐no

Questionnaire reviewed and appropriate health education provided
Date_____ Staff signature/Title _____