Wills Valley Family Medicine

Po Box 890, Collinsville Al 35961 Phone Number 256-524-3090 Fax 256-524-2885

Name_____ DOB_____

Past Medical Questionnaire

Please List any Major Illness/ health problems **ex. Hypertension, Diabetes, migraines etc.**

1._____Year_____ 4._____Year_____

2._____Year_____ 5._____Year_____

3._____Year_____ 6._____Year_____

Surgical Operations /Serious Injuries

1._____Year_____ 4._____Year_____

2._____Year_____ 5._____Year_____

3._____Year_____ 6._____Year_____

Health Maintenance

Please let us know date if your last (if you refuse any of this please write **Decline**)

Bone Density: _____ Where?_____ _____Eye Exam: _____ Where?_____ ____

Pneumonia shot:_____ Tetanus shot: _____Last Pap smear:_____Podiatry Exam_____

Mammogram: _____ Where?_____ Colonoscopy/Hemmoccult cards:_____ Where?_____

Family History

Please indicate if any person, RELATED BY BLOOD, had any of the following: Indicate Maternal or Paternal Grand mother / Grand father

Condition	Yes	No	Relationship	Condition	Yes	No	Relationship
Hypertension				Thyroid			
Stroke				Seizures			
Asthma				Diabetes			
Vision Problems				Heart problems			
Mental Problems				High Cholesterol			
Cancer (TYPE)							
List any other major health problems							

Medications Please list medicines, dosage and how they are taken. _____

_____

_____

PLEASE BRING MEDICATIONS TO YOUR APPOINTMENT, IF YOU DO NOT BRING MEDICATIONS WE WILL HAVE TO RESCHEDULE YOUR APPOINTMENT

Social History

Do you Exercise Y N Type of exercise_____ Do you use Alcohol? Y N Amount per Day_____

Do You use Tobacco? Y N Amount per Day_____ IF previous, year quit _____Years smoking _____

Have you had any falls in the last 6 months? Y N If so how many times? _____