

Buffalo Medical Group, P.C. ®
HEALTH HISTORY QUESTIONNAIRE

Name <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Referring doctor:		Primary doctor:	
Pharmacy Name & Address & Phone	Reason for Visit:		

SURGICAL HISTORY-
Please include any past Colonoscopies or Endoscopies - Use back of page if necessary

Year	Surgery	Hospital

List any medical problems that other doctors have diagnosed- diabetes, high blood pressure, etc.

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers- Use back of page if necessary

Medication	Dose	Frequency	Medication	Dose	Frequency

ALLERGIES

Medication	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	How many drinks per week?		
Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes - pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day
	# of years or year quit		<input type="checkbox"/> Cigars - #/day

FAMILY HEALTH HISTORY

	Mom	Dad	Sister	Brother	Daughter	Son	Paternal Grandparents	Maternal Grandparents	Other
Ovarian Cancer									
Colon Cancer									
Colon Polyps									
Inflammatory Bowel Disease									
Uterine Cancer									
Breast Cancer									
Other Cancer									

*** Please complete this form and bring it with you to your appointment ***