advanced WOUNDCARE
& Hyperbaric Medicine of Michigan

HEALTH HISTORY QUESTIONNAIRE

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

Name: (Last, First, M.I.):					▫ M ▫ F	**DOB:**
Marital status:	▫ Single	▫ Partnered	▫ Married	▫ Separated	▫ Divorced	▫ Widowed
Living Conditions:	▫ Alone	▫ With Family	▫ Nursing Facility	▫ Assisted Living	▫ Skilled nursing facility	
Referring doctor:			**Date of last physical exam:**			
Home Health Agency:			**Pharmacy:**		**Number:**	

PERSONAL HEALTH HISTORY

Medical History

Year	Diagnoses

Surgeries

Year	Type of Surgery	Hospital

Hospitalizations

Year	Reason	Hospital

Please list any medications you are currently taking or attach a list		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction to Medication	Onset Date

PERINENT MEDICAL HISTORY			
Major Injuries	▫ Please list, date, and describe any major injuries:		
Diagnostic Testing	Type of Testing:	Date:	Results:
	Chest x-ray		
	EKG		
	MRI (Location): _____		
	CT Scan (Location): _____		
	EEG		
	SPECT Scan		
	PFT		
	Other: _____		
Therapies	Type of Therapy:	Date & Length of Therapy	Progression?

SOCIAL HISTORY

Alcohol	How often did you have a drink containing alcohol in the past year?			
	▣ Never ▣ Monthly or less ▣ 2-4 times a month ▣ Two to three times per week ▣ four or more times a week			
Tobacco	Do you use tobacco?	▣ Yes ▣ No	Smoke Cigarettes – # packs/day:	
	Former Smoker	▣ Yes ▣ No	▣ # of years	
	▣ Year quit			
Drugs	Do you currently use recreational or street drugs?		▣ Yes	▣ No
Personal Safety	Have you had a fall within the last 3 months?		▣ Yes	▣ No
	Do you have frequent falls?		▣ Yes	▣ No
	Do you have vision or hearing loss?		▣ Yes	▣ No
	Do you wear hearing aids?		▣ Yes	▣ No
	Do you wear glasses or contacts?		▣ Yes	▣ No
	Do you have an Advance Directive or Living Will?		▣ Yes	▣ No
	If yes, do you have a copy to provide for RegenQuest		▣ Yes	▣ No

FAMILY HEALTH HISTORY					
	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	▣ M ▣ F	
Mother				▣ M ▣ F	
Sibling	▣ M ▣ F			▣ M ▣ F	
	▣ M ▣ F			▣ M ▣ F	
	▣ M ▣ F		**Grandmother** Maternal		
	▣ M ▣ F		**Grandfather** Maternal		
	▣ M ▣ F		**Grandmother** Paternal		
	▣ M ▣ F		**Grandfather** Paternal		