Cooley Dickinson Medical Group
Northampton Family Medicine

*All New Pts*

# Health Questionnaire

CDMG 2050 10/16

Name: _____DOB: _____/_____/_____ Date: _____/_____/_____

Please list any concerns you would like to discuss with the provider: _____

_____

Current medical problems: _____

_____

Past surgical procedures: _____

_____

Occupation: _____

Occupational Hazards (such as lead, asbestos, etc.): _____

Married Single Divorced Widowed Separated Partnered

Do you smoke or use smokeless tobacco? Circle: Yes/ No Cigarettes Cigars Pipe Snuff Chew

If no, did you ever smoke? Circle: Yes/ No Quit when? _____ Cigarettes per day/Number of years: _____

Do you drink alcoholic beverages? Yes/ No If yes, quantity, how often: _____

Do you use recreational drugs? Yes/No If yes, please specify**:** _____

Do you drink coffee, tea, or cola? Yes/ No If yes, how much daily? _____

Do you exercise regularly? Yes/ No _____

**Family History:**

| Member | Status (alive/ deceased) | Year of Birth | Age | Medical History |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |
| Maternal Grand mother | | | | |
| Maternal Grand father | | | | |
| Paternal Grand mother | | | | |
| Paternal Grand father | | | | |
| Brothers/Sisters | | | | |
| Aunts/Uncles | | | | |
| Son(s) | | | | |
| Daughter(s) | | | | |