Medical Health Questionnaire

Tabitha Lustig ARNP, FNP-BC
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Phone: (509) 943-6800 Fax: (509) 491-3900

Today's Date:__/__/____

Name:_____ M/F Date of Birth:__/__/____

Previous Primary Care Physician: _____

Reason for your visit:_____

Current Medication and Dosage:

_____

_____

Known Allergies (med, food, environment):

_____

Past Medical History	Year Diagnosed
Asthma	
Anemia	
Cancer	
Cholesterol	
COPD	
Diabetes	
Heart Disease	
Hypertension	
Kidney	
Migraine	
Stroke	
Thyroid	

Past Surgical History	Date
Angioplasty/Stenting	
Appendix	
Gall Bladder	
Open Heart Surgery	
Orthopedic	

Any Hospitalization or Mental Illness
_____
_____

Personal and Occupational History:

Married__ Single__ # of Children___

Birth Control_____

Occupation_____

Occupational Hazards_____

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Family History:

Cancer__ Depression__ Diabetes__ Heart Disease__ Hypertension__ Stroke__ Thyroid__
Other_____

Gynecological History: LMP__/__/____ Abnormal Bleeding/Pap **Y/N** Postmenopausal **Y/N**

Social History	Year Started	Amount per Week
Alcohol		
Caffiene		
Diet		
Drug Use (including marijuana)		
E-Cigarette		
Tobacco (smoking or chewing)		

Immunizations		Date
Covid 19	**Y or N**	__/__/____
Flu	**Y or N**	__/__/____
Pneumovax 23	**Y or N**	__/__/____
Prevnar 20	**Y or N**	__/__/____
RSV	**Y or N**	__/__/____
Shingles	**Y or N**	__/__/____
Tetanus	**Y or N**	__/__/____

Health Screenings	Date	Results
Colorectal Cancer (45-75)	__/__/____	
DEXA (65+)	__/__/____	
Last Physical Exam	__/__/____	
Mammogram (40+)	__/__/____	
Vision (yearly)	__/__/____	