Medical Associates of the Hudson Valley

Personal and Family Health History Questionnaire Form

Please complete both pages of this medical history form and send back to the office. Thank you.

Main address: 360 Washington Ave. Kingston, N.Y. 12401

Phone #: 845-338-7140 **Fax #: 845-338-7141** **MAHV Email: contact.mahv@gmail.com**

Date: _____ Name:_____ Date of birth: _____

Please list all dates, name of doctors and/or facilities for all procedures performed or N/A if non-applicable.

Procedure:	Date last Performed:	Location:	Doctors Name:
Physical			
PAP			
Mammography			
Colonoscopy			
Endoscopy			
Pneumonia Vaccine			
Prevnar Vaccine			
Flu Vaccine			
Zosta Vaccine (Shingles)			
Covid Vacc. Dates	Moderna ◉ Pfizer ○ J & J ○	1st dose _____	2nd dose _____
Bone Density			
Exercise Stress			
Chest X-Ray			
Sleep Study			
Echocardiogram			
Pulmonary function test			
Blood Work			
Lyme Testing			

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Allergies **(List all)** _____

Medical Problems **(List all)** _____
_____

Foot Exam and Doctor **(If Diabetic)** _____
Eye Exam and Doctor **(If Diabetic)** _____

Surgeries **(List all with dates & locations preformed)** _____
_____

Hospitalizations **(List all with dates and hospital names, EXCLUDING SURGERIES)** _____
_____

Medications **(List all meds with name and dosage, including daily over the counter meds and supplements)**

_____

_____

Family Medical History: (Please list any known illnesses, cancers, or medical conditions, if relative is living or deceased [if so, cause of death])

Father _____
Mother _____
Siblings _____

Social History
Marital Status _____
Number of Children _____
Miscarriage or Abortions _____
Occupation _____
Lives with _____

Personal Habits
Diet: Regular ☐ Healthy ☐ Diabetic ☐ Gluten Free ☐ Vegetarian ☐ Vegan ☐
Other: _____

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Have you ever been a smoker?
Never ☐ Former ☐ Current ☐ # of packs per day _____
Cigarettes ☐ Cigars ☐ Vape ☐ Other _____
Start date: _____ End date: _____

Alcohol consumption: Wine ☐ Beer ☐ Liquor ☐
Quantity: Daily ☐ Weekly ☐ Occasional ☐ None ☐

Marijuana Use (Type of use): Medical ☐ Recreational ☐
Non-Prescription Drug Use (Other than marijuana): _____

Daily Caffeine (Cups daily): Coffee _____Tea _____ Soda _____ Decaf _____

Exercise Type/Frequency Active ☐ Moderate ☐ Inactive _____

Sleep Habits: Good ☐ Fair ☐ Poor ☐ Trouble falling asleep ☐ Trouble staying asleep ☐
CPAP/BiPAP _____ Hours of sleep _____ Other _____

Hand Dominance: Right ☐ Left ☐ Ambidextrous ☐