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 (3rd floor)

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			
Blood Work/Lyme Testing			
Bone Density			
Covid Vaccine Dates	**Moderna____** **Pfizer____** **J & J_____**	**1st dose _____**	**2nd dose _____**
Consent for Vaccine download from NYSIIS	**Yes_____** **No_____**		
List any radiology or imaging (MRI, CT, X-Ray)			

Allergies **(List all)** _____
(Allergy Consults) Pets & Flooring Materials_____

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

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

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

Medical Associates of the Hudson Valley

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, <u>if relative is living or deceased [if so, cause of death])</u>

Father _____
Mother _____

<u>Social History</u>
Marital Status _____
Miscarriage or Abortions _____
Occupation/Retired From_____

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 _____

Sleep Habits: Good _____ Fair _____ Poor _____ Trouble falling asleep _____ Trouble staying asleep _____
CPAP/BiPAP _____ Sleep Study (Date/Facility Performed at) _____

Hand Dominance: Right ____ Left ____ Ambidextrous ____

Please list any other providers on your care team that we would be able to obtain records from.

_____

_____

_____