New Horizon Research Group

Medical Affiliated Research Center
303 Williams Ave. Suite 511
Huntsville, AL 35801
(256) 533 - 6603

North Alabama Research Center
721 W. Market St. Suite B
Athens, AL 35611
(256) 771 - 9919

Cullman Research Center
909 Graham St. SW Suite D
Cullman, AL 35055
(256) 735 - 4262

Health History Questionnaire

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

Patient Name:	**DOB:**

PERSONAL HEALTH HISTORY

Immunizations and Dates:	□ **Tetanus** _____ □ **Hepatitis** _____ □ **Influenza** _____ □ **Pneumonia** _____ □ **Shingles** _____ □ **Chickenpox** _____ □ **Other:** _____	**COVID-19** (check one) □ **Pfizer** □ **Moderna** □ **AstraZeneca** □ **Johnson & Johnson** **Date(s):** _____

List any Medical Problems / Diagnosis

Surgeries

Year	Reason	Date

Hospitalizations

Year	Reason	Date

Have you ever had a blood transfusion? (circle one)	**YES** **NO**	Date

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Health History Questionnaire

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List your prescribed medications / inhalers and any over-the-counter medications, such as vitamins		
Medication Name	Strength	Frequency Taken

Allergies to Medications	
Name the Drug	Reaction You Had

Health Habits and Lifestyle Questionnaire

All Questions Contained in this section are optional and will be kept STRICTLY confidential.

Exercise	□ Sedentary (no exercise) □ Mild Exercise (Climb stairs, walk 3 blocks, golf) □ Occasional Vigorous Exercise (work or recreation, less than 4x/week for 30 mins/day) ☐ Regular Vigorous Exercise (work or recreation, 4x/week longer than 30 mis/day)		
Caffeine	□ Coffee (cups/day) _____ □ Tea (glasses/day) _____ □ Cola (cans/day) _____ □ Energy Drinks (cans/day) _____		
Alcohol	□ Never □ Monthly or less □ 2-4 times per month □ 2-3 times per week ☐ ≥ 4 days a week		
Tobacco	What kind of tobacco/nicotine products do you use? □ Never Smoked □ Former Smoker (year you quit) _____ □ Cigarettes (packs/day) _____ □ Cigars (#/day) _____ □ Chewing Tobacco (#/day) _____ □ Pipe (#/day) _____ □ Vape		
Drugs	Do you currently use recreational or street drugs? (circle one)	**YES**	**NO**
Sex	Are you sexually active? If yes, are you trying for a pregnancy?	**YES** **YES**	**NO** **NO**

WOMEN ONLY

Date of last menstruation	
# of Pregnancies	
# of Births	

□ Hysterectomy (year) _____ (circle one) **COMPLETE** **PARTIAL**
□ Ablation (year) _____
□ Menopause (year) _____