

**HEALTH HISTORY QUESTIONNAIRE**

Today's Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Primary Care Doctor's Name and Address \_\_\_\_\_  
\_\_\_\_\_

Referring Doctor's Name and Address \_\_\_\_\_  
\_\_\_\_\_

Other Doctor's Who care for you currently \_\_\_\_\_  
\_\_\_\_\_

**REASON FOR TODAY'S VISIT**

**Social History (Self)**

AGE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ RIGHT HANDED \_\_\_\_yes / \_\_\_\_ no LEFT HANDED \_\_\_\_yes / \_\_\_\_ no

Married / Single / Divorced / Widowed / Separated (circle one) Do you have children \_\_\_\_yes / \_\_\_\_no

Are you currently working \_\_\_\_yes / \_\_\_\_no Occupation \_\_\_\_\_

Do you smoke \_\_\_\_yes / \_\_\_\_no If yes how many packs per day \_\_\_\_\_ How many years \_\_\_\_\_

Do you drink alcohol \_\_\_\_yes / \_\_\_\_no If yes how many drinks per week \_\_\_\_\_

Do you use street drugs \_\_\_\_yes / \_\_\_\_no What drugs do you use \_\_\_\_\_

Have you traveled outside the United States within the last 12 months \_\_\_\_yes / \_\_\_\_no

**WOMEN ONLY:** Is there a chance you might be pregnant \_\_\_\_yes / \_\_\_\_no

**FAMILY HISTORY:** Note any significant family medical history \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST MEDICAL HISTORY**

Please indicate whether or not you have previously had or have any of the following---

	YES	NO		YES	NO
Thyroid Disease			Cancer		
Heart Disease			Chemotherapy		
Drug Dependency			Radiation Therapy		
High Blood Pressure			Glaucoma		
Heart Murmur			Arthritis		
Rheumatic Fever			HIV/AIDS		
Congenital Heart Lesions			Immune Deficiency Disease		
Artificial Heart Valve			Hepatitis A, B or C		
Heart Pacemaker			Fainting or Dizzy Spells		
Heart Surgery			Liver Disease, Cirrhosis		
Artificial Joints (Hip/Knee)			Yellow Jaundice		
Stroke			Blood Transfusions		
Kidney Trouble			Hemophilia		
Ulcers			Prolonged Bleeding		
Emphysema			Diabetes		
Cough			Veneral Disease		
Tuberculosis (TB)			Epilepsy		
Asthma			High Cholesterol		
Mental Health Problems (anxiety, depression, bipolar, etc)			Fibromyalgia		

Please describe any medical problems not listed above \_\_\_\_\_

**PAST SURGERY HISTORY (please list all surgeries/operations and dates)**

Name of Surgery	Date	Name of Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____

**MEDICATIONS**

(please list all of the medications you take on a regular basis-- include herbal, hormones, birth control)

Name of Medication	Dosage	Name of Medication	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**ALLERGIES TO MEDICATIONS (please list any allergies to medications, foods, anesthesia)**

Name	Reaction
_____	_____
_____	_____

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_