HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**	**AGE:**
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			

PERSONAL HEALTH HISTORY

Vitals: Height: _____ Weight: _____

List any medical health problems that other doctors have diagnosed below

Surgeries

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise)	☐ Mild exercise	☐ Occasional vigorous exercise	☐ Regular vigorous exercise			
Diet	Are you dieting?				☐	Yes	☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola			
Alcohol	Do you drink alcohol?				☐	Yes	☐ No
Tobacco	Do you use tobacco?				☐	Yes	☐ No
Drugs	Do you currently use recreational or street drugs?				☐	Yes	☐ No

FAMILY HEALTH HISTORY

Family Member	Diagnosis
Mom	
Dad	
Sister	
Brother	