Phone: _____
Cell: _____

Health Questionnaire

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible.

Last Name:	First name:	D.O.B. / /	Male	Female
Presenting problem:				

YES	NO	MEDICAL HISTORY	YES	NO	MEDICAL HISTORY
		High blood pressure			Diverticulosis
		Diabetes			Thyroid problems
		Ulcers			Asthma
		Heart Murmur/Valve Disorder			C.O.P.D.
		Stroke			Alcohol Abuse
		Heart Attack			Smoker, and if so packs per day _____
		Cancer			Depression
		Gall stones			Anxiety
		Kidney stones			Other (Please list):
		Blood transfusion			
		Immunological disorder			

Family History: Please indicate health status or cause of death, diseases related to presenting problem &/or hereditary or high risk diseases.	
Mother:	Father:
Siblings:	Children:

Please list names and dates of all operations and surgeries you have had. NONE

Name of operation/surgery	Year	Complications

Medications: Please list names and dosages, including over the counter medications and supplements. NONE

Name of medication	Dosage/Frequency	Name of medication	Dosage/Frequency

Allergies to Medication: Please list any medications and reactions. NONE

Name of medication	Reaction	Name of medication	Reaction

To the best of my knowledge, the above information is true and accurate.

Patient signature (parent or guardian if patient is a minor): _____ Date: _____

Reviewed by: _____ D.O./MD/PA-C/NP Date:_____