

PERSONAL HEALTH HISTORY INFORMATION

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

Name:	Date of Birth:	Date:	
Name of referring provider:		<input type="checkbox"/> Self referred	
MEDICAL HISTORY			
<input type="checkbox"/> High Blood	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma, Hay Fever
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Other Medical problems: _____			
Surgeries: <input type="checkbox"/> Partial hysterectomy <input type="checkbox"/> Complete hysterectomy <input type="checkbox"/> Gallbladder <input type="checkbox"/> Cardiac bypass <input type="checkbox"/> Appendectomy <input type="checkbox"/> Cataracts <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Thyroidectomy			
Other surgeries: _____			
Hospitalizations/Major Injuries: _____ _____			
Family history is positive for the following: <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease <input type="checkbox"/> Other			
MEDICATION (prescription and over the counter) Please bring your bottles so we can verify your medication or bring an attached list or list below with name , strength, frequency			
_____ _____ _____			
<u>Allergies or Adverse Reactions to medications or other substances below:</u> _____ _____			
SOCIAL HISTORY			
Do you use: nicotine? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Cigars <input type="checkbox"/> Chewing tobacco			
Do you drink any alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes How much? <input type="checkbox"/> occasional <input type="checkbox"/> daily			
Do you exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes How much? <input type="checkbox"/> occasional <input type="checkbox"/> daily			
Are you? <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			