Health History Questionnaire - Demographics

PATIENT NAME: _____

LEGAL SEX:

- MALE
- FEMALE

DATE OF BIRTH: _____

ADDRESS (home, city, state, zip code):

_____

CELL PHONE: _____

OTHER PHONE: _____

EMAIL: _____

PREFERRED LANGUAGE: _____

MARITAL STATUS:

- Married
- Single
- Divorced
- Widowed
- Partner

EMERGENCY CONTACT (name, relationship and phone number):

_____

Health History Questionnaire – Insurance

EMPLOYER NAME AND PHONE NUMBER:

_____

INSURANCE GUARANTOR:

- Self
- Spouse
- Parent
- Other

GUARANTOR NAME AND DATE OF BIRTH (if not self):

_____

GUARANTOR MAILING ADDRESS AND PHONE (if not self):

_____

INSURANCE PLAN: _____

MEMBER ID: _____

SECONDARY INSURANCE PLAN: _____

MEMBER ID: _____

Health History Questionnaire – Clinical Information

REASON FOR TODAY'S VISIT:

_____
_____

ALLERGIES:

_____

MEDICATIONS (name and dose):

_____
_____
_____
_____
_____
_____

FAMILY MEDICAL HISTORY (parents, siblings, children) – mark all that apply:

- High blood pressure
- Diabetes
- High cholesterol
- Stroke
- Other _____

SMOKING HISTORY – mark only one oval:

- Never smoker
- Former smoker
- Current every day smoker
- Some days smoker

ILLICIT DRUG HISTORY – mark any that you use recreationally:

- Marijuana
- Vape

- Other

ALCOHOL HISTORY – (how often you have had an alcoholic beverage in the past year) - mark only one oval:

- None
- Monthly or less
- 2-4 times per month
- 2-3 times per week
- 4 or more times per week

SURGICAL HISTORY:

_____
_____
_____

MEDICAL HISTORY – mark all that apply:

- High blood pressure
- Diabetes
- High Cholesterol
- Thyroid disorder
- Heart disease
- Stroke
- Cancer
- Depression/anxiety
- Kidney disease
- Liver disease
- Lung disease
- Autoimmune disease (Lupus, Rheumatoid Arthritis, etc)
- Bleeding or clotting disorder
- Other: _____

PREFERRED PHARMACY AND PHONE NUMBER:

_____

****We do not see cases associated with a current/prior Workman Comp claim, Motor Vehicle Accident or Third Party Insurance *****

I certify that my symptoms are not related to a current/prior Workman Comp Claim, Motor Vehicle Accident and no third party will be expected to provide payment for service

_____

Patient Signature and Date