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Health Questionnaire

Name: _____ DOB: _____ Date: _____

Marital Status: _____ Occupation: _____ Referred by: _____

PAST MEDICAL HISTORY/CHRONIC ILLNESSES:

PAST SURGICAL HISTORY:

MEDICATIONS: [Please list the name, dose, and directions of the medicine(s)]

DRUG ALLERGIES:

SOCIAL HISTORY:

Have you ever smoked? ☐ YES ☐ NO Are you still smoking? ☐ YES ☐ NO Amount smoked: _____

How much alcohol do you drink? _____ Recreational drugs: _____

Number of Children: _____ Current birth control method: _____

FOR WOMEN ONLY: Date of last period: _____ Number of pregnancies: _____

FAMILY HISTORY:

Mother: ☐ ALIVE ☐ DECEASED

MEDICAL CONDITIONS: _____

Father: ☐ ALIVE ☐ DECEASED

MEDICAL CONDITIONS: _____

Siblings:

MEDICAL CONDITIONS: _____

Other relatives:

MEDICAL CONDITIONS: _____