Today's Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential.

Name *(Last, First, M.I.):* ☑ M ☑ F	**DOB:**
Marital status: ☑ Single ☑ Partnered ☑ Married ☑ Separated ☑ Divorced ☑ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed (i.e. Asthma, Diabetes, Hypertension, Hyperlipidemia)

Surgeries		
Year	Reason	Hospital

Other medical OR psychiatric hospitalizations		
Year	Reason	Hospital

Allergies to medications	
Name the Drug	Reaction You Had

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

If you need more room to list medications or problems, please write them in at the bottom of the next page.

SOCIAL AND HEALTH HABITS

Tobacco	Do you use tobacco?			☑ Yes ☑ No
	☑ Cigarettes – pks./day	☑ Chew - #/day	☑ Pipe - #/day	☑ Cigars - #/day
Highest level of education:				
Religious affiliation (if any):				
Employer:				
Job Title:				
Do you have children? ☑ Yes ☑ No	**If yes, how many? _____**			

WOMEN ONLY

Have you experienced menopause?	☑ Yes	☑ No
Approximate date of last menstrual cycle:		
Are you sexually active?	☑ Yes	☑ No
If yes, are you trying for a pregnancy?	☑ Yes	☑ No
If not trying for a pregnancy, list contraceptive or barrier method used:		

If you need more room to list medications or problems, please write them in on the back of this page.