Patient Health History Questionairre

Name (Last, First, M.I.)_____ Date: _____
Date of Birth:_____
Phone: Home: _____ Work: _____ Cell: _____
Primary Medical Doctor:_____
Were you referred by your primary doctor? □Yes / □No
If not, how did you hear about us? □ Other M.D. / □ Family / □ Friend / □ Internet

What is the primary reason you are here today? _____

Health History
Please list any operations/ surgeries with approximate dates:
_____
_____
_____
Please list medications you are currently taking with dosages:
_____
_____
_____
Do you have any allergies to medications? □ Yes / □ No. If answer is YES, please list and describe what happened when you took that medicine.
_____
_____
Pleas list any hospitalizations with cause, approximate dates:
_____
_____
Please list any chronic medical conditions (e.g. High blood pressure, diabetes, etc.):
_____
_____
Please list any family history of disease or illness, or health status of immediate family:
_____
_____
Please list your current height and weight:
Height: _____ Weight: _____
Have you had a flu shot?
□ Yes / □ No Date: _____

Please check the following areas if you currently have any problems or related complaints:

□ **General health** (fevers, weight loss, malaise)	□ **Musculoskeletal** (arthritis, osteoporosis)
□ **Cardiovascular** (heart attack, irregular heartbeat, chest pain)	□ **Skin** (eczema, psoriasis, acne)
□ **Respiratory** (asthma, emphysema, shortness of breath)	□ **Neurologic** (stroke, seizures)
□ **Gastrointestinal** (gastric reflux, ulcers, difficulty swallowing, abdominal pain, bleeding, liver disease)	□ **Psychiatric** (depression, mania, schizophrenia)
□ **Genitourinary** (prostate problems, incontinence)	□ **Endocrine** (thyroid,diabetes)
□ **Allergic/Immunologic** (immune deficiency, known environmental allergies)	□ **Eyes** (glaucoma, cataracts, blurred vision)

Do you smoke? □ Yes / □ No If yes, how much (i.e. packs/day)_____ and for how many years?_____
Do you regularly consume alcoholic beverages? □ Yes / □ No If yes, how many drinks daily?_____
What is your current employment/ occupation?_____
What is your marital status? □ Single □ Married □ Divorced □ Widowed □ Partner

Office use only. *I have reviewed the above information with the patient.*
M.D.