



# HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential.

<b>Name</b> (Last, First, M.I.):		<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB:</b>
<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
<b>Previous or referring doctor:</b>		<b>Date of last physical exam:</b> <b>Highest Education Received:</b>	

## PERSONAL HEALTH HISTORY

**Reason for visit:**

**List any medical problems that other doctors have diagnosed**

**Surgeries**

Year	Reason	Hospital

**Other hospitalizations**

Year	Reason	Hospital

**Have you ever had a blood transfusion?**  Yes  No

**List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**

Name the Drug	Strength	Frequency Taken

**Continued list of prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**

Name the Drug	Strength	Frequency Taken