

**CONFIDENTIAL
HEALTH HISTORY QUESTIONNAIRE**

Name _____ Age _____ Date _____

Give a brief statement of your general health _____
(Excellent, Good, Fair, Poor)

If you check yes to any question below, describe problems in detail.

	YES	NO	Details of Medical History
1. Do you have any current medical problems?	_____	_____	_____
2. Does your health prevent you from participating in any physical activities?	_____	_____	_____
3. Have you had any chronic illnesses, serious illnesses or physical disabilities?	_____	_____	_____
4. Have you ever been under the care of a psychologist, psychiatrist, or counselor?	_____	_____	_____

HOSPITALIZATIONS/SURGERY/BROKEN BONES						
YEAR	REASON					
	Have you ever been advised to have any surgical operation that has not been performed?					
ALLERGIES: LIST MEDICATION/OTHER ALLERGIES		CURRENT MEDICATIONS: LIST ALL MEDICATIONS, BIRTH CONTROL, OVER-THE-COUNTER AND HERBAL MEDICATION, DOSAGES AND WHY				
		Medication	Dose	Why you are taking medication		
IMMUNIZATIONS	DATES			FAMILY PHYSICIAN	ADDRESS	PHONE
DTP/DTAP						
HIB						
POLIO (series of 3)				OB/GYN:		
HEPATITIS B (3)						
MMR				SPECIALISTS:		
MANTOUX/Tb						
CHICKEN POX						
TETANUS						
PNEUMOVAC						
FLU SHOT						
OTHER						

PAST MEDICAL HISTORY : Have you or your immediate family (mother, father, sibling, child) ever been told you have had:								
CONDITION	YES	NO	FAMILY	CONDITION	YES	NO	FAMILY	
Fatigue, Insomnia or Weakness				Arthritis				
Ear, Nose, or Throat problems				Shoulder, Arm, wrist problems				
Allergies to dust, mold, pollen, food, etc.				Carpal Tunnel Syndrome				
Eye or vision problems				Back or Neck Problems				
High Blood pressure or low blood pressure				Leg, Ankle, Foot or Knee problems				
Heart Attack, Chest Pain, or Stroke				Cerebral Palsy or physical problems				
Heart Problems or Irregular Heart beat				Hernias				
Heart murmur				Gout				
Rheumatic fever				Kidney or Urinary Problems				
Scarlet fever				Prostatitis or prostate cancer				
Scarletina				Liver or Spleen problems				
Blood clot in lung, legs, etc				Pancreatitis				
Lung Problems: Asthma, Bronchitis, Pneumonia				Diabetes				
Tuberculosis, positive TB test or exposure				Thyroid or pituitary problems				
Emphysema or Chronic Cough				Colitis, diverticulitis or Crohns disease				
Head injuries, concussions				Ulcer, Intestinal, Abdominal problems				
Frequent Headaches or Migraines				Hepatitis, Jaundice				
Meningitis				Gallbladder disease				
Aneurysm				Anemia, Sickle cell or other bleeding				
Epilepsy or Seizures				Blood or plasma transfusions				
Dizziness, Blackouts, or Fainting				Eczema, psoriasis or other skin problems				
Neurologic problems				Exposure to hazardous chemicals				
Anxiety, Depression or Mental disorders				Cancer or tumors				
Suicide attempt				Lupus				
Drug or Alcohol Abuse				Lyme disease				
Addiction to narcotics				Malaria				
Anorexia, Bu lemia or other eating disorders				Measles				
Obesity				German Measles				
Abnormal Pap Smear, dysplasia, cervical cancer				Mumps				
Endometriosis, ovary, tube, or uterus problems				Chicken Pox				
Sexual transmitted diseases G/C, Syphilis, etc				Polio				
Herpes, warts, HPV				Pertussis or Whooping Cough				
Bacterial vaginosis				Diphtheria				
Pelvic Inflammatory Disease				Small Pox				
Sexual dysfunction, erectile dysfunction				Any other Medical Condition not listed				

COMMENTS: Please explain all YES responses:

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SOCIAL HISTORY

	YES	NO	# PER DAY	HOW MANY YEARS?	YEAR QUIT
Do you drink alcohol?					
Do you smoke or chew tobacco?					
Do you smoke marijuana?					
Do you take any illegal drugs?					
Do you live with someone or have a family member that does any above?					

