HEALTH HISTORY QUESTIONNAIRE

Important: *Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.*

All information is strictly confidential

I. General Patient Information

Date: ___ / ___ / _____ Name: _____

Address: _____

City, State, Postal Code: _____

Home Phone: (_ _ _) _ _ _ - _ _ _ _ Work Phone: (_ _ _) _ _ _ - _ _ _ _

May we contact you: ☐ at home ☐ at work ☐ email: _____

Age: _____ Date of Birth: ___ / ___ / _____ Place of Birth: _____

Gender: ☐ male ☐ female Height: _____ Weight: _____ lbs.

Occupation: _____ Employer: _____

Hours worked per week _____ Is your health complaint related to work? ☐ Yes ☐ No ☐ Maybe

How did you hear about our office? _____

Guardian (if under 18): _____

Person to notify in an emergency: _____ Relationship: _____

Daytime phone for above person (_ _ _) _ _ _ - _ _ _ _

Major Complaint(s), in order of significance to you:

1. _____ 4. _____
2. _____ 5. _____
3. _____ Additional: _____

How do these conditions impair your daily activities? _____

_____

Do you exercise or have a routine? _____

Are you happy? _____

Do you like your work? _____

Do you consider yourself healthy? _____

II. Patient Medical History

How was your childhood health? _____

Hospital Visits/Stays/Dates: _____

_____

_____

Recent tests: (please indicate test results and date below)

☐ Physical ☐ Cholesterol ☐ Prostate ☐ Blood (which?)

☐ HIV/STD ☐ Pap Smear ☐ Mammography ☐ Other: _____

Test Results and Date: _____

_____