Date:

HEALTH HISTORY QUESTIONNAIRE

Name *(Last, First, M.I.):*			☐ M ☐ F	**DOB:**	
Address	**City**		**State**	**Zipcode**	
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed					
Family Physician/Primary Care Physician:			**Date of last physical exam:**		

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Mononucleosis ☐ Zoster ☐ Diphtheria ☐ Whooping Cough ☐ German Measles		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical diagnosis and whether the medical issue is resolved or ongoing

Surgeries

Year	Reason	Hospital

Other Hospitalizations or Procedures (including orthopedic injuries)

Year	Reason	Hospital

Please turn to next page

DOCTOR CONTACT AND INSURANCE INFORMATION

TYPE	NAME	PHONE CONTACT	MEDICAL INSURANCE CARRIER NAME		
Primary Care				**ID**	**GROUP NUMBER**
Dentist					

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

ADDITIONAL INFORMATION

I have a Living Will: ☐ Y ☐ N	I have an Advanced Directive: ☐ Y ☐ N	Power of Attorney:

MEDICATIONS

Medication Name/Dosage	***Route of Administration/Frequency Taken***	***Reason Prescribed***

ALLERGIES

Known Allergies	***Type of Reaction***