PERSONAL HEALTH HISTORY INFORMATION

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name: **Date of Birth:** **Date:**

Name of referring provider: ☐ Self referred

MEDICAL HISTORY

☐ High Blood	☐ Heart Trouble	☐ Diabetes	☐ Asthma, Hay Fever
☐ High Cholesterol	☐ Diabetes	☐ Thyroid Disorder	☐ Pneumonia

☐ Other Medical problems: _____

Surgeries: ☐ Partial hysterectomy ☐ Complete hysterectomy ☐ Gallbladder
☐ Cardiac bypass ☐ Appendectomy ☐ Cataracts ☐ Tonsillectomy ☐ Thyroidectomy

Other surgeries:

Hospitalizations/Major Injuries:

_____

_____

Family history is positive for the following:
☐ Diabetes ☐ Hypertension ☐ Thyroid disease ☐ Osteoporosis ☐ Cancer
☐ Heart disease ☐ Other

MEDICATION (prescription and over the counter)
Please bring your bottles so we can verify your medication or bring an attached list or list below with name , strength, frequency

_____

_____

_____

Allergies or Adverse Reactions to medications or other substances below:

_____

_____

SOCIAL HISTORY

Do you use: nicotine? ☐ No ☐ Yes
☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing tobacco

Do you drink any alcohol? ☐ No ☐ Yes How much? ☐ occasional ☐ daily

Do you exercise? ☐ No ☐ Yes How much? ☐ occasional ☐ daily

Are you? ☐ Married ☐ Single ☐ Divorced ☐ Separated