Health History Questionnaire

All questions contained in the questionnaire are strictly confidential & will become part of your medical record.

Legal Name *(Last, First, MI)*:	**First Name Used:**	**DOB:**

MEDICATIONS

List ALL medications & supplements you are currently taking (including OTC vitamins & herbals). Please list the medication name, strength in milligrams, & dosage frequency as written on the prescription bottle.

I take no RX/OTC medications, herbals, or supplements. ☐

PHARMACY

NAME_____ **PHONE**_____

ADDRESS_____

SOCIAL HISTORY

Do you or have you ever smoked tobacco?	NEVER ☐ FORMER ☐ CURRENT EVERY DAY ☐ CURRENT SOME DAYS ☐ UNKNOWN ☐
Has tobacco cessation counseling been provided?	YES ☐ NO ☐ If yes, date tobacco cessation counseling was provided:_____
What is your level of alcohol consumption?	NONE ☐ OCCASIONAL ☐ MODERATE ☐ HEAVY ☐
Do you use any illicit or recreational drugs?	YES ☐ NO ☐

SURGICAL HISTORY

Please list ALL past surgeries & implanted devices.
If you've had any BRAIN, NECK, or BACK surgeries, list the surgeon & year it was performed.

I have no surgical history. ☐

PAST MEDICAL HISTORY

Please check each applicable diagnosis.

A-FIB ☐	CANCER ☐	DIALYSIS ☐	HYPERTENSION ☐	OTHER ☐
AIDS/HIV ☐	CHOLESTEROL (HIGH) ☐	ESSENTIAL TREMOR ☐	INCONTINENCE ☐	PACEMAKER ☐
ANESTHESHIA TROUBLE ☐	CHRONIC WOUNDS/ POOR HEALING ☐	GERD ☐	KIDNEY DISEASE ☐	PARKINSON'S DISEASE ☐
ANXIETY ☐	COPD ☐	HEADACHES ☐	LIVER DISEASE ☐	PROSTATE PROBLEMS ☐
ARTHRITIS ☐	CORONARY ARTERY DISEASE ☐	HEART ATTACKS ☐	MRSA ☐	SEIZURES ☐
AUTO-IMMUNE DISORDER ☐	CPAP ☐	HEART FAILURE ☐	NEUROPATHY ☐	STENTS ☐
BLEEDING TOO EASILY ☐	DEPRESSION ☐	HEPATITIS ☐	O2 USE ☐	STROKE ☐
BLOOD CLOTS ☐	DIABETES ☐	HYDROCEPHALUS ☐	OSTEOPOROSIS ☐	THYROID DISEASE ☐

I have no medical history. ☐

FAMILY HEALTH HISTORY

Please place a check next to those applicable to you and write which family member.

BLOOD COAGULATION DISORDER ☐	DIABETES MELLITUS ☐	CANCER ☐
CEREBROVASCULAR ACCIDENT ☐	HEART DISEASE ☐	BRAIN TUMOR ☐

I have no family history to report. ☐

ALLERGIES

Please list ALL drug, food, and/or medical allergies and our reaction.

I have no allergies to report. ☐

Do you have any other pertinent history, symptoms, or information to provide?