Health History Questionnaire

Patient Name: ______________________________

Pharmacy preference, location, phone and fax: (this will allow us to fax prescriptions directly to your pharmacy)

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Do you take any medications (prescription, over the counter, or herbal)? No

If yes, please list:

Medication name:	Dosage:	Taken how often:

Are you allergic to any medications? No If yes, please list:

Medication name:	Type of reaction:

Have you ever been diagnosed with any of the following: (circle your answers)

I do not have any chronic condition.

Cancer (type:________________)	Heart attack	Gastro-intestinal reflux
	Heart disease	Hepatitis
Migraines	High blood pressure	Prostate problems
Glaucoma	Asthma	Diabetes
Allergies	Ulcers	Thyroid problems

Please list any other conditions: ______________________________

Have you had any problems with anesthesia? No

If yes, please describe: ______________________________

Please list any surgeries you have had: None

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Please list any other hospitalizations you have had: None

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Family History: (circle any of the following diseases of your parents, grandparents, siblings)

	Family history is not known	
Anesthetic problems	Heart disease	Diabetes
Cancer	Hypertension/high blood pressure	Thyroid disease
Migraine headaches	Asthma	Bleeding problems
Hearing loss prior to age 20		Allergies

List any inherited problems: ______________________________

Social History:

Are you currently using any tobacco products? No Yes
Have you used tobacco products in the past? No Yes
Do you drink alcohol? No Yes
Are you exposed to any irritants? Smoke Loud noise other: ____________________

REVIEW OF BODY SYSTEMS

Circle if you have recently had any of these symptoms:

Ear	Nose	Mouth / Throat
Drainage Hearing loss Ringing	Congestion Runny nose Sneezing	Change in voice Snoring Trouble swallowing
Heart	**Respiratory**	**Digestive**
Chest pain Heart murmur Irregular heartbeats	Non-productive cough Productive cough Wheezing	Abdominal tenderness Heartburn/indigestion Painful swallowing
Bone and Joints	**Skin**	**Brain and Nervous System**
Painful joints Swelling of joints Weakness	Moles that have changed Lump in the skin Rashes	Change in smell Change in vision Loss of consciousness
Mental Health	**Blood and Lymph**	**Allergy**
Nervousness/anxiety Depression Trouble sleeping	Excessive bleeding Bruise easily Lumps in neck	Food intolerance Hives Swelling of face or tongue

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