Health History Questionnaire

Patient Name: _____

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

_____

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

_____

_____

_____

_____

_____

Please list any other hospitalizations you have had: None

_____

_____

_____

_____

_____

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

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