Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First, M.I.):* ☐ M ☐ F **DOB:**	
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Primary or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Allergies:		
Medications:		

List any medical problems that other doctors have diagnosed

1.)
2.)
3.)
4.)

Surgeries

Year	Reason	Hospital

	Height: Weight:	Shoe Size:
	Do you smoke ____Yes ____No	
	Are you taking Coumadin or any blood-thinning medications?	
	Are you insulin-dependent?	
	Have you had any joint replacements?	
	I am seeing the doctor today for:	

Is this a work related injury? If yes, date of the injury __/__/__

Pharmacy Name:

Please turn to next page