HEALTH QUESTIONNAIRE

Patient Name: _____ **Today's Date:** _____

Your insurance company requires the following information for proper payment. Please fill out completely.

Reason for visit: _____

1. Please describe the nature of your symptoms and list each symptom.
   (e.g. nasal congestion, phlegm in throat, ear ache, etc.)

_____

_____

2. How long has each of these symptoms been present? (e.g. sore throat- 2 weeks, ear pain- 2 days)

_____

3. Have you taken any medications or had past treatment/evaluation for present symptoms? ☐ Yes ☐ No

   If yes, list each medication along with the dosage, length of time taken, when medication was finished, and how many per day:

_____

4. Any other details you would like to mention?

_____

5. Do you have any drug/environmental allergies? ☐ Yes ☐ No
   If yes, please list below along with any reaction you have to the drug and/or environmental allergy:

_____

Past Medical History: Do you have (or have you in the past) any of the following conditions? If yes, please mark the appropriate box(es) and give details in the space provided.

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer (Type:_____)
- ☐ Depression
- ☐ Diabetes
- ☐ Females: Are you currently pregnant?
- ☐ Hay fever/Allergies
- ☐ Headaches/ Migraines
- ☐ Heart disease
- ☐ High blood pressure
- ☐ HIV related disease
- ☐ Mental Illness
- ☐ Pneumonia
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Venereal disease

Other: _____

Please Fill Out The Other Side

Medications: Please list all medications currently taken and dosage, if known:

_____

_____

_____

Surgical History: Please list any operations/procedures you have ever had and when they occurred:

_____

_____

Family History: If any blood relative has suffered any of the following, please mark the appropriate box(es) and indicate which relative.

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Hay Fever/ Allergies
- ☐ Headaches/ Migraines
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Menieres Disease
- ☐ Mental Illness
- ☐ Thyroid Disease
- ☐ None of the above

Other: _____

Social History: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Partner

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per day? _____

Do you smoke? ☐ Yes ☐ No If yes, how many cigars/cigarettes per day? _____

Have you smoked in the past? ☐ Yes ☐ No If yes, how many years? _____

per day? _____

date quit? _____

Occupation: _____

Please List Your:
Height _____
Weight _____