Health Questionnaire

Name: Age: Date:

Who referred you to this physician?

Why are you here today?

Please list any conditions or chronic illnesses you have (such as high blood pressure, diabetes, etc):

Please list all currently prescribed medications (including those taken for chronic conditions, birth control, etc) as well as all those taken regularly without a prescription (such as aspirin, antacids, vitamins, allergy pills, etc.):

☐ none

Please list any herbal products you are currently using: ☐ none

Please list allergies to foods or medications: ☐ none

Please list all surgeries including the approximate date or age each was performed (surgery / date / age): ☐ none

1.	2.
3.	4.
5.	6.

Do you smoke? ☐ never ☐ no, when did you quit? ☐ yes, how long?

How much alcohol do you normally consume in a week?

How many cups or glasses of caffeine-containing beverages do you normally consume in a day?

Is there any additional information you feel the physician should know concerning your past health?

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