

HEALTH HISTORY QUESTIONNAIRE

NAME _____ DATE _____

WEIGHT _____ HEIGHT _____

Past history of medical problems, illnesses, injuries (circle all that apply):

Decreased Hearing
Thyroid Problems
Lung Problems
High Blood Pressure
Heart Attack
Hardening of Arteries
Murmur
Other Heart Condition
Stroke
Headaches
Head Injury

Stomach/Ulcer
Colitis
Other Bowel Problems
Hepatitis
Liver Problems
Gallbladder Problems
Hernia
Kidney/Bladder Problems
Prostate Problems
Mental Health
HIV

Anemia
Bleeding Tendency
Diabetes
Endocrine
Glandular Problems
Polio
Cancer or Tumor
Convulsions/Seizures
Arthritis
Arrhythmias
Other: _____

Current medications _____

Natural or herbal supplements _____

Previous surgeries _____

Are you allergic to any medications? If so, which ones _____

Diseases that may run in the family _____

Do you drink alcoholic beverages _____ If yes, how often/much _____

Do you smoke _____ If yes, how often/much _____

Occupation _____

Reviewed by Physician _____