



Health History Questionnaire

Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Reason for Visit: \_\_\_\_\_ Age \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Medical Conditions \_\_\_\_\_

Allergies \_\_\_\_\_

Medications \_\_\_\_\_

Surgeries \_\_\_\_\_

Tobacco Use No Yes Quit: \_\_\_\_\_  
Alcohol No Yes less than 1/week 1-2/week 1-2/day >2/day  
Illicit Drug Use No Yes If yes which ones? \_\_\_\_\_

Occupation \_\_\_\_\_

Activities/sports \_\_\_\_\_

Family medical problems:

Mother \_\_\_\_\_

Father \_\_\_\_\_

Grandparents \_\_\_\_\_ Brothers/Sisters \_\_\_\_\_

Do you have any problems with your health listed below?

- Senses:** Eyes/vision Hearing Dizziness Loss of Balance
- General:** Fatigue Weight loss Weight gain Loss of appetite Fever/chills
- GI:** Heartburn Diarrhea Constipation Nausea Eating disorder
- Circulatory:** Chest pain Palpitations Cold hands or feet Leg pain walking  
Swelling of legs Leg pain at night History of blood clot
- Lungs:** Shortness of breath Asthma Cough Sleep Apnea Bronchitis
- Nerves:** Burning/tingling/numbness in feet Muscle weakness Nerve problems
- Bone and Joint:** Joint pain Back pain Difficulty walking Gout  
Difficulty going up or down stairs Loose or unstable joints
- Skin:** Rash Dry/itching Nail problems Frequent wounds Nail problems
- Immune system:** Frequent illness or infection Swollen joints or hands Night sweats  
Swollen lymph nodes Mouth sores Dry mouth/eyes Fever/chills

Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe size \_\_\_\_\_