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NAME	M F	DATE OF BIRTH	DATE

HEALTH QUESTIONNAIRE

REASON FOR VISIT _____

FAMILY HISTORY

	ALIVE & WELL	DECEASED	FOLLOW THE LINES ACROSS THE PAGE AND MARK THE APPROPRIATE BOX CAUSE OF DEATH (AGE)	HIGH BLOOD PRESSURE	HEART DISEASE	EPILEPSY	DIABETES	CANCER	ASTHMA	HAYFEVER	ARTHRITIS	KIDNEY DISEASE	GLAUCOMA	STROKE	MIGRAINE	MENTAL ILLNESS	ALCOHOLISM	BLEEDS EASILY	ANEMIA	PSORISIS	ECZEMA
FATHER																					
MOTHER																					
BROS / SIS																					
BROS / SIS																					
BROS / SIS																					
BROS / SIS																					
MOTHER'S RELATIVES																					
FATHER'S RELATIVES																					

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS THAT YOU ARE NOW TAKING INCLUDE OVER THE COUNTER RX	NAME	STRENGTH	HOW OFTEN	NAME	STRENGTH	HOW OFTEN
				DRUG ALLERGIES		

MEDICAL HISTORY Mark C for current problems. ☑ x and indicate age when you had any of the following symptoms or diseases

___ HEARING PROBLEMS
___GLAUCOMA
___NOSE BLEEDS
___HOARSENESS
___ASTHMA
___CORONARY HEART DISEASE
___HEART MURMUR
___PALPITATIONS
___VARICOSE VEINS
___DIFFICULTY SWALLOWING
___PEPTIC ULCER DISEASE
___JAUNDICE
___KIDNEY STONES
___VENEREAL DISEASE
___CATARACTS
___SINUS TROUBLE
___HAY FEVER
___HYPERTENSION
___IRREG. PULSE

___PHLEBITIS
___HEARTBURN
___COLITIS
___HEPATITIS
___PROSTATE PROB.
___HERPES
___GONORRHEA
___BRUISE EASILY
___THYROID DISEASE
___CHLAMYDIA
___RECENT WEIGHT LOSS
___ANEMIA
___CANCER
___DIABETES
___SEIZURES
___MIGRAINE HEADACHES
___ARTHRITIS
___DEPRESSION
___TUBERCULOSIS

___ALLERGIES (NON DRUG)
___STROKE
___GOUT
___MENTAL ILLNESS
___ALCOHOL OZ / WK _____
___SMOKING-CIG / DAY ____ YRS____
___COFFEE/TEA CUPS / DAY ___

FEMALES

No. OF PREGNANCIES ____
No. OF LIVE BIRTHS ____
No. OF MISCARRIAGES ____
BIRTH CONTROL _____
B.C. PILL (BRAND) _____
MENOPAUSAL SYMPTOMS ____YES ____NO
REGULAR MENSTRUAL PERIODS ____YES ____NO

SKIN PROBLEMS

___ECZEMA
___ABNORMAL MOLES
___FREQUEST SUN EXPOSURES
___EXCESSIVE SCARRING
___SKIN CANCER
___RECENT OR PROGRESSIVE HAIR LOSS
___PSORIASIS
___RASH
___HIVES
___ACNE
___OTHER _____