

HEALTH HISTORY QUESTIONNAIRE

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All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name	DOB:
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Height:

Weight:

PERSONAL HEALTH HISTORY

Are you a smoker: Y N Pacemaker: Y N Defibrillator: Y N Diabetes: Y N

List any medical problems that other doctors have diagnosed:

Surgeries:

Year	Reason	Hospital

Other hospitalizations:

Year	Reason	Hospital

List your prescribed drugs:

Name the Drug	Strength	Frequency Taken

Allergies to medications or other:

Name the Drug	Reaction You Had