

History and Health Questionnaire

Name: _____ Date: _____ Chart #: _____

Please check if Applicable: _____

HAVE YOU HAD:

- Anemia
- Asthma
- Bleeding Problems
- Cancer
- Cold Sores
- Diabetes
- Enlarged Glands
- Fainting Spells
- Hayfever
- Heart Disease
- High Blood Pressure
- Low Blood Pressure
- Paralysis
- Phlebitis
- Seizures
- Thrombosis
- Thyroid (Overactive)
- Thyroid (Underactive)
- Varicose Veins

FAMILY HISTORY:

- Bleeding Problems
- Cancer
- Diabetes
- Heart Disease

PROBLEMS WITH EYES:

- Diseases
- Dryness
- Excessive Tearing
- Impaired Sight
- Injury

PROBLEMS WITH NOSE:

- Injury
- Nose Bleeds
- Sinuses

Any decreased sensation in any part of the body? If yes, please explain: _____

PLEASE LIST ALL MEDICATIONS THAT YOU USE REGULARLY:

Allergies:

- | | |
|--|--------------------------------------|
| Adhesive Tape <input type="checkbox"/> | Mycins <input type="checkbox"/> |
| Antitoxin <input type="checkbox"/> | Penicillin <input type="checkbox"/> |
| Aspirin <input type="checkbox"/> | Serums <input type="checkbox"/> |
| Codeine <input type="checkbox"/> | Sulfa Drugs <input type="checkbox"/> |
| Demerol <input type="checkbox"/> | Tetanus <input type="checkbox"/> |
| Latex <input type="checkbox"/> | Valium <input type="checkbox"/> |
| Morphine <input type="checkbox"/> | |

Any other drugs or anti-biotics, etc: _____

Have you been hospitalized for any medical illness or surgical procedure: Yes No

If yes, please explain: _____

DO YOU USE:

- | | |
|---|---|
| Aspirin/Blood Thinners <input type="checkbox"/> | Sleeping Pills <input type="checkbox"/> |
| Hormone Replacements <input type="checkbox"/> | Tranquilizer <input type="checkbox"/> |
| Sedatives <input type="checkbox"/> | Vitamin E <input type="checkbox"/> |

DO YOU SMOKE? Yes No If so, how many packs per day: _____

Do you currently use any Herbal, Vitamin Supplements or Weight Control Substances? Yes No

If yes, please specify: _____

Have you had a PAP Smear within the last three years? Yes No

When was your last Mammogram? Date: _____

Date of your last PHYSICAL EXAM? _____

Please list current height and weight Height: _____ Weight: _____

I attest that the above information is true and correct



Signature