HEALTH QUESTIONNAIRE

Date____________________

Name________________________________ Address__________________________________
Last First Middle Number & Street

____ H _______________ B ________________
City State Zip Home and Business Phone

Date of Birth_____________ Height_________ Weight________ Occupation____________________

Married ☐ Spouse's name _________________________ Single ☐ Email_____________

Patient Employed by:__________________________ Spouse Employed by:___________________________

Patient's social Security # _____________________________ Spouse's social Security # _____________________________

If you are completing this form for another person, what is your relationship to that person?

____

Referred by: ____

PLEASE ANSWER EACH QUESTION CIRCLE

1. Have you been a patient in a hospital during the past 2 years? YES NO
2. Have you been under the care of a physician during the past 2 years? YES NO
3. Have you taken any kind of medicine or drugs during the past year? YES NO
4. Are you allergic to penicillin, codeine or any other drugs or medicine? YES NO
5. Have you ever had any excessive bleeding requiring special treatment? YES NO
6. Do you smoke and how much? ___________________________ YES NO
7. (Women) Are you pregnant now? YES NO
8. Have you had any other serious illnesses or operations? YES NO
9. Circle any of the following which you have had:

heart trouble	yellow jaundice	tuberculosis	psychiatric treatment
congenital heart lesions	liver disease	hepatitis	sinus trouble
heart murmur	asthma	arthritis	tumors – growths
anemia	cough	stroke	pacemaker
rheumatic fever	diabetes	epilepsy	aids
			venereal disease

10. Name of physician ____________________________Phone # _________________________

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Current Medications Reason

THANK YOU

____
Patient's (Parent's if a minor) Signature

DATE SERVICE RENDERED

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