HEALTH QUESTIONNAIRE

PATIENT NAME: ______________________________ **DATE OF BIRTH:** ____________

Do you have an Advance Directive? ____________ If so, does this office have a copy? ____________

Please list your medication allergies: ______________________________

____

Please list your current medications, including over the counter meds. Please include dose and directions for each med:

1. ______________________________ 6. ______________________________
2. ______________________________ 7. ______________________________
3. ______________________________ 8. ______________________________
4. ______________________________ 9. ______________________________
5. ______________________________ 10. ______________________________

Are you a smoker? ____________ Cigarettes or Cigars? ____________ How many per day? ____________

Do you consume alcoholic beverages? ____________ How often? ____________

Do you use illegal drugs? ______________________________

Please list any chronic medical conditions/past illnesses (e.g. asthma, high blood pressure, diabetes):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Please list any past surgeries:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Please list any family health history (heart problems, breathing issues, cancers, chronic diabetes, etc.):

Mother ______________________________

Father ______________________________

Siblings ______________________________

Maternal Grandmother ______________________________

Maternal Grandfather ______________________________

Paternal Grandmother ______________________________

Paternal Grandfather ______________________________