HEALTH QUESTIONNAIRE

DATE ____________ DOB ____________ AGE ____________ WT ____________ HGT ____________ SEX ☐ M ☐ F

Patient name Last / First / Middle ____

Reason for the visit

Duration of condition

Treatement tried

List all allergies to medications

Listo hospitalizations/surgeries

Cosmetic surgeries/procedures

Medical conditions

List al medication/vitamins taken daily

Brith weight ____________________ Apgar ____________

FEMALES ONLY

Are you pregnant? ☐ Yes ☐ No how many weeks ____________ Birthcontrol method? ____________

Number of pregnancies ____________ Are you breast feeding? ☐ Yes ☐ No

Are you planning to get pregnant ☐ Yes ☐ No When? ____________

Regular menstrual period ☐ Yes ☐ No Date of last menstrual period ____________

Menopausal symptoms of postmenopausal? ☐ Yes ☐ No Age onset ____________

SOCIAL HISTORY

Work status: Employed ____________ Unemployed ____________ Occupation ____________

Live alone ☐ Yes ☐ No Hobbies ____________

Do you have pets? ☐ Yes ☐ No School/daycar? ☐ Yes ☐ No Smoke ☐ Yes ☐ No

What do you smoke? ____________ How often ____________

Alcohol consuption ☐ Yes ☐ No how often? Daily ☐ Socially ☐ Ocasionally ☐ Never ☐

Do you use any recreational drugs? ____________

Sexually active with one partner ____________ Sexually active with more than one partner ____________