Name: _____ DOB: _____ CH:_____

Healthcare Questionnaire
New/Returning Patients

Self		Women Only
Anemia		On any type of birth control _____
Asthma		What age did you start your period _____
Anxiety		When was your last period _____
Atrial Fibrillation		How many days does your period last? _____
Chronic Renal Failure		How many abortions/miscarriages _____
Benign Prostatic Hyperplasia (BPH)		How many times have you been pregnant _____
COPD		Age at first birth? _____
Congestive Heart Failure		When did you enter menopause?
Coronary Artery Diseas		I have not started menopause
Diabetes 1		I am currently going through menopause
Diabetes 2		
Diverticulitis		
Diverticulosis		
Gallstones		
GERD		
Hepatitis A		
Hepatitis B		
Hepatitis C		
HIV/AIDS		
High Cholesterol		
Elevated Lipids		
High Blood Pressure (hypertension)		
HyPERthyroidism		
HyPOthyroidism		
Kidney Stones		
Obesity		
Osteoarthritis		
Osteoporosis		
Stroke		
Seizure		
Blood Disorder (type) _____		
Cancer (type/location) _____		
Other _____		

Name: _____ DOB: _____ CH:_____

Allergies

Medication Allergies		Reaction
Aspirin		
Penicillin		
Codeine		
Local Anesthetics		
Latex		
Sulfa Drugs		
Other		

Surgical History

Procedural/Surgical History	Date	Who Performed
Colonoscopy		
Cancer Surgery		
Pap Smear		
Mammogram		
Bone Density		
Any Iron Treatments		
Pacemaker		
Back Surgery		
Other		

Social History

Smoking	Drinking		Marital Status
Date Started _____	Do not drink		S
Date Quit _____	Socially		M
Never _____	Daily Amount		W
How many packs per day _____	Other		D
How many years _____			

Name: _____ DOB: _____ CH:_____

Family History

	Living	Deceased (age/cause)
Mother		
Father		
Number of brothers		
Number of sisters		
Number of children		
Boy (s)		
Girls (s)		

Please list your current medications, strength and how often you take this medicine

	MEDICATION	STRENGTH	HOW OFTEN YOU TAKE
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			