

Original Date:

Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Previous or Referring Doctor:		Date of Last Physical Exam:	

PERSONAL HEALTH HISTORY

Childhood Illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever			
Immunizations and Dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox	
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <small>Measles, Mumps, Rubella</small>	

List Any Medical Problems That Other Doctors Have Diagnosed

<div></div>

Surgeries

Year	Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

Have You Ever Had a Blood Transfusion?

☐ Yes ☐ No