Adult Health History Form

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

Name		M	F	DOB	
Marital Status	Single	Partnered	Married	Separated	Divorced	Widowed
Previous or Referring Doctor		Date of last physical exam			

PERSONAL HEALTH HISTORY

Childhood Illness	Measles	Mumps	Rubella	Chickenpox	Rheumatic Fever	Polio

Immunizations and dates				
	Tetanus		Pneumonia	
	Hepatitis		Chickenpox	
	Influenza		MMR	

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?