

Patient History Questionnaire

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Todays Date: _____

Medical Information

What is your general health? _____

Do you have any problems with any of these systems?

Gastrpointestinal	Y/N	Muscle/Bone	Y/N
Nervous	Y/N	Headaches	Y/N
Blood/Lymph	Y/N	Respiratory	Y/N
Ears/Nose/Throat	Y/N	Integumentary (Skin)	Y/N
Urinary	Y/N	Mental	Y/N
Allergic/Immunologic	Y/N	High Blood Pressure	Y/N
Cardiovascular	Y/N	Eyes	Y/N

Other: _____

Diabetes: Y/N Type: _____ Date of Diagnosis: _____

Allergies to medication? Y/N
Which? _____

Other Allergies? Y/N
Which? _____

Current Medications: _____

Have you had any operations? _____

Do you smoke? Y/N
Drink alcohol? Y/N
History of drug abuse? Y/N

