



History and Health Questionnaire

Name: _____ Date: _____ Chart #: _____

Please check if Applicable:

HAVE YOU HAD:

- Anemia, Asthma, Bleeding Problems, Cancer, Cold Sores, Diabetes, Enlarged Glands, Fainting Spells, Hayfever, Heart Disease, High Blood Pressure, Low Blood Pressure, Paralysis, Phlebitis, Seizures, Thrombosis, Thyroid (Overactive), Thyroid (Underactive), Varicose Veins

FAMILY HISTORY:

- Bleeding Problems, Cancer, Diabetes, Heart Disease

PROBLEMS WITH EYES:

- Diseases, Dryness, Excessive Tearing, Impaired Sight, Injury

PROBLEMS WITH NOSE:

- Injury, Nose Bleeds, Sinuses

Any decreased sensation in any part of the body? If yes, please explain: _____

PLEASE LIST ALL MEDICATIONS THAT YOU USE REGULARLY:

Allergies:

- Adhesive Tape, Antitoxin, Aspirin, Codeine, Demerol, Latex, Morphine, Mycins, Penicillin, Serums, Sulfa Drugs, Tetanus, Valium

Any other drugs or anti-biotics, etc: _____

Have you been hospitalized for any medical illness or surgical procedure? Yes No
If yes, please explain: _____

DO YOU USE:

- Aspirin/Blood Thinners, Hormone Replacements, Sedatives, Sleeping Pills, Tranquilizer, Vitamin E

DO YOU SMOKE? Yes No If so, how many packs per day?
Do you currently use any Herbal, Vitamin Supplements or Weight Control Substances? Yes No
If yes, please specify: _____

Have you had a PAP Smear within the last three years? Yes No
When was your last Mammogram? Date:
Date of your last PHYSICAL EXAM?
Please list current height and weight: Height: Weight:

I attest that the above information is true and correct
Signature