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.):* ☐ M ☐ F **DOB:**

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation: **Date of last physical exam:**

PERSONAL HEALTH HISTORY

Immunizations and dates: ☐ Tetanus ☐ Pneumonia Shot ☐ Influenza ☐ Hepatitis ☐ Other

List any medical problems that other doctors have diagnosed

YEAR	CONDITION

Surgeries/ Hospitalizations

YEAR	REASON	HOSPITAL

Please turn to next page