



Health History Questionnaire

Name: _____ Age: _____ Date of Birth: _____

Address: _____ Nickname: _____

_____ Today's Date: _____ Gender: _____

Home Phone: _____ Cell Phone: _____ Referred By: _____

Current Complaint/Illness (please describe): _____

_____ E-Mail Address: _____

Current Adult Medical Conditions

(i.e. high blood pressure, diabetes, etc.)

Date

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medical Allergies

Previous Surgeries

Date

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications with Dosage

Social History

Amount

Duration

Cigarettes: _____

Pipe/Cigar: _____

Chewing: _____

Alcohol : _____

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____