



Acct#: _____

HEALTH AND HISTORY QUESTIONNAIRE

Dear Patient: Please complete this questionnaire and bring it with you on your first visit to our office. This gives you the convenience of filling this form out at home where your records may be more accessible to you.

Please attach additional sheets if needed. Thank you in advance - we look forward to seeing you!

Name: _____ Preferred Name: _____ Date: _____

D.O.B. _____ Age: _____ Ht: _____ Wt: _____

Surgeries: Please list any surgeries you have had in the past (ex: tonsils, gallbladder, hysterectomy, wisdom teeth, etc.). Please include any cosmetic surgeries as well:

| Surgery Type | Year |
|--------------|------|
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Allergies: (Including soaps, tape, latex, food, shellfish, medicines, etc.)

| Allergy | Reaction |
|---------|----------|
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Medications: List all medications you are taking. (Please include vitamins, supplements, herbals, steroids, prescribed medications and any over the counter medications such as: aspirin, ibuprofen or other NSAIDS.

| Medication | Dose/Strength | How Often? | Why are you taking? |
|------------|---------------|------------|---------------------|
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Reviewed by: _____ Date: _____



Acct#: _____

Name: _____ Date: _____

Patient History:

For what medical or mental conditions have you previously been or are currently being treated?

Please list any untreated conditions as well such as: MVP, diabetes, chronic back pain, etc.

What prosthetic devices do you have in your body? (Plates, screws, Greenfield filter, silicone joints, breast implants, etc.)

Lesion / Skin Cancer: _____ Size: _____ Present How Long? _____

Location / Site: _____

When did symptoms start? _____

How has it changed? _____

Biopsy done? _____ What doctor? _____

Sun Exposure: _____ History of Skin Cancer: _____

Family History - Please list any medical conditions that have existed in your immediate family (blood relations):

Social History:

Do you currently smoke cigarettes? _____ How many packs per day? _____ For how long? _____

If you do not currently smoke, have you smoked in the past? _____ When did you quit? _____

Do you use any other tobacco products? _____ Please specify: _____

Do you drink alcohol or have you in the past? _____ How many drinks per day? _____ For how long? _____

Do you take recreational drugs? _____ Please specify: _____

Are you on a special diet? _____ If so, please explain: _____

Any body piercings? _____

Which of the following activities are you required to perform on the job:

- | | | |
|--|--------------------------------|--|
| <input type="checkbox"/> Lift _____ pounds | <input type="checkbox"/> Sit | <input type="checkbox"/> Use computer |
| <input type="checkbox"/> Lift over head | <input type="checkbox"/> Bend | <input type="checkbox"/> Operate heavy equipment |
| <input type="checkbox"/> Reach over head | <input type="checkbox"/> Stand | <input type="checkbox"/> Drive |

Hobbies / Leisure Activities: _____
