Health History Questionnaire

Patient Information

Name: _____ **Date of birth:** _____ **Gender:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Email:** _____

Emergency Contact Name: _____

Emergency Contact Number: _____ **Relationship to Emergency Contact:** _____

Medical History

1. Have you ever been hospitalized? If yes, please provide details.

2. Have you had any surgeries? If yes, please provide details.

3. Do you have any allergies? If yes, please provide details.

4. Do you have any chronic medical conditions? If yes, please provide details.

5. Do you have a history of mental health conditions? If yes, please provide details.

6. Do you have a history of substance abuse? If yes, please provide details.

7. Do you have a family history of medical conditions? If yes, please provide details.

Current Medications

Please list all current medications you are taking, including dosage and frequency.

Immunization History

Are you up-to-date on your vaccinations? If not, please provide details.

Lifestyle Factors

1. Do you smoke? If yes, how many cigarettes per day?
2. Do you drink alcohol? If yes, how many drinks per week?
3. Do you use recreational drugs? If yes, please provide details.
4. Do you exercise regularly? If yes, please provide details.
5. Do you have a balanced diet? If no, please provide details.

Women's Health (if applicable)

1. Are you pregnant? If yes, how many weeks?
2. Do you use any form of contraception? If yes, please provide details.
3. Do you have irregular periods? If yes, please provide details.
4. Have you experienced menopause? If yes, please provide details.

Additional Questions

1. Is there anything else you think we should know about your health history?
2. Is there anything else you would like to discuss with your healthcare provider?