NEW PATIENT (ADULT) HEALTH HISTORY QUESTIONNAIRE

IN ORDER TO GET TO KNOW YOU BETTER, PLEASE ANSWER THE FOLLOWING QUESTIONS:

LAST NAME _____ FIRST NAME _____ MI ____

AGE _____ DATE OF BIRTH ____/____/_____ SOCIAL SECURITY NUMBER ____/____/____

PRIMARY CARE PHYSICIAN _____ PHONE # _____

WHAT IS THE NATURE OF THE PROBLEM THAT BROUGHT YOU TO THE OFFICE TODAY? _____

_____

GENERAL HEALTH HISTORY
PLEASE CIRCLE THE APPROPRIATE ANSWER OR PROVIDE INFORMATION WHERE NECESSARY

HEIGHT _____FT _____ IN WEIGHT _____ RACE _____ SEX MALE ____ FEMALE ____

PLEASE RATE YOUR CURRENT HEALTH STATUS POOR AVERAGE GOOD EXCELLENT

PLEASE RATE YOUR ENERGY LEVEL POOR AVERAGE GOOD EXCELLENT

DO YOU CURRENTLY SMOKE? YES / NO HOW LONG? (YEARS) _____ HOW MANY PACKS /DAY? _____

HAVE YOU SMOKED IN THE PAST? YES / NO WHEN DID YOU STOP? _____ HOW MANY PACKS/DAY? _____

DO YOU CONSUME ALCOHOL BEVERAGES? YES / NO TYPE? BEER / WINE / LIQUOR

HOW OFTEN? DAILY / 2-3 TIMES PER WEEK / ON WEEKENDS / ON RARE OCCASIONS

DO YOU EXERCISE REGULARY? YES / NO HOW OFTEN? DAILY / 2-3 TIMES PER WEEK / RARELY

HAVE YOU GAINED WEIGHT OVER THE LAST 5 YEARS? YES / NO IF YES, HOW MANY LBS.? _____

HAVE YOU **LOST** WEIGHT OVER THE LAST 5 YARS? YES / NO IF YES, HOW MANY LBS.? _____

DO YOU HAVE, **OR** HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS?

CARDIAC	NO / YES / PAST / CURRENT
BLOOD PRESSURE	NO / YES / PAST / CURRENT
STROKE	NO / YES / PAST / CURRRNT
CANCER TYPE _____	NO / YES / PAST / CURRENT
PULMONARY / RESPIRATORY	NO / YES / PAST / CURRENT
DIABETES / HYPOGLYCEMIA	NO / YES / PAST / CURRENT
GASTRO / INTESTINAL PROBLEMS	NO / YES / PAST / CURRENT
BLEEDING / BLOOD CLOTTING PROBLEM	NO / YES / PAST / CURRENT
NEUROLOGIC	NO / YES / PAST / CURRENT
PSYCHIATRIC	NO / YES / PAST / CURRENT
ALLERGIES / HAY FEVER	NO / YES / PAST / CURRENT
ENDOCRINE / HORMONAL	NO / YES / PAST / CURRENT
NASAL OBSTRUCTION / CHRONIC SINUSUTIS	NO / YES / PAST / CURRENT

THROAT / VOICE / HOARSENESS	NO / YES / PAST / CURRENT
LANGUAGE / ARTICULATION / RESONANCE	NO / YES / PAST / CURRENT
HEARING LOSS / BALANCE OR DIZZINESS	NO / YES / PAST / CURRENT
OTHER _____	NO / YES / PAST / CURRENT

ARE YOU ALLERGIC TO ANY MEDICATIONS ? YES / NO IF YES, PLEASE LIST _____

_____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS ? (PRESCRIPTION AND/OR NON-PRESCRIPTION) YES / NO

MEDICATION _____ DOSE _____

MEDICATION _____ DOSE _____

MEDICATION _____ DOSE _____

MEDICATION _____ DOSE _____

MEDICATION _____ DOSE _____

MEDICATION _____ DOSE _____

YOU USE ANY BLOOD THINNERS SUCH AS COUMADIN OR ASPRIN ? YES / NO _____

DO YOU USE ANY HERBAL "ALTERNATIVE" OR VITAMINS SUPPLEMENTS ? YES / NO _____

_____

DO YOU USE ANY TYPE OF "DIET PILLS" YES / NO _____

HAVE YOU HAD ANY SURGERIES ? YES / NO IF YES, PLEASE LIST

SURGERY _____ YEAR OF SURGERY _____

SURGERY _____ YEAR OF SURGERY _____

SURGERY _____ YEAR OF SURGERY _____

SURGERY _____ YEAR OF SURGERY _____

PREGNANCIES ? YES / NO IF YES, NUMBER OF PREGNANCIES _____

PATIENT SIGNATURE _____ DATE _____

THANK YOU FOR YOUR ASSISTANCE!