

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 YEARS? 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
LANGUAGE / ARTICULATION / RESONANCE
HEARING LOSS / BALANCE OR DIZZINESS
OTHER _____

NO / YES / PAST / CURRENT
NO / YES / PAST / CURRENT
NO / YES / PAST / CURRENT
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!