



HEALTH QUESTIONNAIRE

To Be Completed by the Patient – Please Print

Name: _____ Today's Date ____ / ____ / ____

Date of Birth: ____ / ____ / ____

List of Drug Allergies & Reactions _____

Please List Chronic Medical Conditions and Surgeries (do not include normal pregnancies)

Year	Chronic Medical Conditions

Year	Chronic Medical Conditions

Dx: _____

**FAMILY HISTORY; Has any blood relative, including children, had any of the following:
 (Circle Yes or no, leave blank if uncertain)**

		<u>Relationship</u>		<u>Relationship</u>
Allergies	Y N	_____	Epilepsy	Y N _____
Anemia	Y N	_____	Heart Disease	Y N _____
Bleeding Tendency	Y N	_____	High Blood Pressure	Y N _____
Cancer	Y N	_____	Stroke	Y N _____
Diabetes	Y N	_____	Tuberculosis	Y N _____

Over Please

