

New Patient Health History Questionnaire

Patients Name: _____ Patient 's Date of Birth: _____

Patient's Family History (Please mark all that apply)																	
Have any of Your Family Members Ever Had...	Father	Mother	Brother				Sister				Spouse	Children					
			1	2	3	4	1	2	3	4		1	2	3	4	5	6
Cancer																	
Diabetes																	
Heart Trouble																	
High Blood Pressure																	
Stroke																	
Asthma, Hives, Hay Fever																	
Blood Disease																	

Patient's Personal History (Please mark all that apply)			
Have you ever had any of the following conditions?			
Chronic Back Pain	Diabetes	Asthma, Hives, Hay Fever	
Chronic Migraine Headaches	Heart Trouble	High Blood Pressure	
Stroke	Cancer	Blood Disease	
Other Conditions Not Specified (Please List):			

Drug Allergies (Please mark all that apply)		Surgeries (Please mark all that apply)	
Penicillin	Sulfa Drugs	Appendix	Tonsils
Aspirin	Codeine	Gallbladder	Hernia
Other Drug Allergies (Please List):		Other Surgeries (Please List):	

Patient/Parent/Legal Guardian Signature: _____ Date: _____

Office Use:

Form is signed and dated by the patient/parent /guardian? Y N Staff initial: _____