Health History Questionnaire

Name: ________________________________ Age: ________ Date of Birth: __________________

Address: __________________________________ Nickname: ______________________________

____ Today's Date: ___________ Gender: ________

Home Phone: ________________ Cell Phone: ________________ Referred By: ______________

Current Complaint/Illness (please describe): ____

___________________________________ E-Mail Address: ________________________________

Current Adult Medical Conditions

(i.e. high blood pressure, diabetes, etc.) Date

Condition	Date

Medical Allergies

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Previous Surgeries

Previous Surgeries	Date

Current Medications with Dosage

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Social History

	Amount	Duration
Cigarettes:		
Pipe/Cigar:		
Chewing:		
Alcohol :		