

Health Questionnaire

Name: _____ Age: _____ Date: _____

HISTORY OF PAST ILLNESS

	<u>DATE</u>	<u>TYPE</u>	<u>HOSPITAL</u>
Serious Illnesses	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Operations	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Injuries	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

FAMILY HISTORY

	AGE	IF LIVING	IF DESEASED	
		HEALTH	AGE (at death)	CAUSE
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers/ Sisters	_____	_____	_____	_____
	_____	_____	_____	_____
Husband/ Wife	_____	_____	_____	_____
	_____	_____	_____	_____
Sons/Daughter	_____	_____	_____	_____
	_____	_____	_____	_____

SOCIAL HISTORY

Birthplace: _____

CIRCLE ONE: Single Married Separated Divorced Widowed

Do you have dependants at home? YES NO If yes how many? _____

Alcoholic beverages: Never Rarely Moderately Daily

Tobacco: Never smoked Quit-when? _____ Packs/day _____

Drugs (illicit): None In Past Rarely Frequently

Exercise: Type _____ Frequency _____

Are you currently dieting? YES NO If so what type of diet? _____

Occupation: _____ Any known Allergies? _____