HEALTH INFORMATION QUESTIONAIRE:

INSURANCE: ____ SELF PAY: _______________

NAME: ____ DATE OF BIRTH: __________

PRIMARY CARE PHYSICIAN: _____________________________________

PHARMACY: _____________________________________ CITY LOCATED IN: _________________

REASON FOR VISIT TODAY:

____

CURRENT SYMPTOMS: ____

CURRENT MEDICATIONS AND DOSAGES: _______________________________________

____

____

ALLERGIES (INCLUDE REACTION): ____

____

HOSPITILIZATIONS/SURGERIES. Include dates: ____

____

Do you smoke or drink alcohol? ___Y ___N How much? _____________________________________

Last Menstrual Period ____

Current method of Birth Control ____

Date of last PAP smear ____

History of abnormal PAP smears, sexually transmitted infections: __________ YES __________NO.

Details: ____

Date of last Mammogram and results: ____

Have you ever had a Colonoscopy? _______ When __________________Result _______________

Have you ever had a Bone Density Test? ___________ When: ____________ Result _______________

How many Pregnancies have you had? __________ Living children? _________ Miscarriages________

C-Sections _______________

Family health history (especially mother, father, brothers or sisters)

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