Comprehensive Health History Questionnaire

Personal Information

Full Name

Date of Birth

Gender

Phone

Email

Address

Emergency Contact

Name

Relationship

Phone

Medical History

Primary Physician

List of past or current medical conditions (e.g., diabetes, asthma, heart disease):

Current Medications (including supplements):

Allergies (medications, foods, environment):

Surgical History

Surgeries and Dates:

Family Medical History

Has any blood relative had any of the following? (Mark all that apply and specify relationship)

e.g., Diabetes (Mother), Hypertension (Father), Cancer (Grandparent)

Social History

Occupation

Marital Status

Select

Do you smoke?

Select

Do you drink alcohol?

Select

Do you use recreational drugs?

Select

Review of Systems

Please list any current symptoms or concerns (e.g., headaches, chest pain, joint pain):

Other Information

Anything else you'd like to share: