Health History Questionnaire

(Take this with you to the Doctor)

Name:_____

Date of Birth:_____

Medical Doctor: _____ Phone:_____

Heart Doctor: _____ Phone:_____

Other Doctor: _____ Phone:_____

Medical History

____ High Blood Pressure	____ Heart Attack	____ Seizures
____ Diabetes	____ Stroke	____ Anxiety/Depression
____ Kidney problems	____ Asthma	

____ Cancer:_____

____ Breathing Problems:_____

____ Bleeding Problems:_____

____ Digestive Problems:_____

Allergies:_____

Medication List:

_____ _____

_____ _____

_____ _____

_____ _____

Hospitalizations: (Date/Reason)_____

_____

Surgeries: (Date/Reason)_____

_____