HEALTH QUESTIONNAIRE

Name: _____

Date:

List all your current health problems:

List any other doctors seen and list treatment received and results obtained:

List all surgeries you have had and list dates:

List any medications you are now taking:

Have you ever been in an automobile accident? When?

Have you ever been in an industrial injury or any other injury for which you received treatment? When?

Please check the conditions you have or have had:

( ) AIDS or HIV+	( ) Epilepsy	( ) Polio
( ) Anemia	( ) Hypoglycemia	( ) Rheumatic Fever
( ) Arthritis	( ) Multiple Sclerosis	( ) Tuberculosis
( ) Cancer	( ) Parkinson's Disease	( ) Venereal Disease

FAMILY HISTORY	age	health problems or cause of death
mother:		
father:		
mother's mother:		
mother's father:		
father's mother:		
father's father:		
brothers:		
sisters:		
children:		