wellbeing

NEW PATIENT
HEALTH HISTORY QUESTIONNAIRE

Name:	☐ **M** ☐ **F**	**DOB**:
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		**Social Security #**

Home Address	Telephone Numbers	OK for us to call you at this Number?
	Home Phone:	☐ Yes ☐ No
	Cell Phone:	☐ Yes ☐ No
City: State: Zip:	Work Phone:	☐ Yes ☐ No
Email:	Fax:	☐ Yes ☐ No

Occupation:	Family Physician:	Emergency Contact:

Past Personal Health History

Please identify the health concerns that have brought you to wellbeing in order of importance below:

Condition	Past Treatment	How does this condition affect you?

Height:	**Weight**:	Past maximum weight:	When:
Blood Pressure: Most recent reading:	When:	**Cholesterol**: Most recent reading: When:	

Have you had any of these childhood illnesses:

Rheumatic Fever ☐ yes ☐ no Diphtheria ☐ yes ☐ no Measles ☐ yes ☐ no Chicken Pox ☐ yes ☐ no

German Measles ☐ yes ☐ no Scarlet Fever ☐ yes ☐ no Mumps ☐ yes ☐ no

If applicable, please list any foods, drugs, or medications, or environmental factors you are hypersensitive or allergic to (please include reaction):

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