# Health History Questionnaire

Patient Name: _____ Patient ID#: _____

When is your next appointment to your referring physician?: _____

Are you presently off from work secondary to your current condition? Yes or No

Please list all medications you are currently taking.

_____
_____
_____
_____

**Health History:**

List any operations you have had including date or any complications.

_____
_____
_____
_____
_____

Explain any other health history you feel may be important in your care (Allergies, Pacemaker, Pregnancy, etc.)

_____
_____
_____
_____
_____

Weight: _____ Height: _____

Do you use tobacco?: _____

Do you drink alcohol?: _____

Have you ever been treated for substance abuse?:

_____
_____