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HEALTH QUESTIONNAIRE

Name: ______________________________________ Date: ___________________

Drug Allergies: ____

Current Medications: ____

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Pharmacy: ____

Past Medical History: Circle ALL that Apply

Arthritis, Bleeding Tendencies, Clots, Cortisone injections, Diabetes, Hepatitis, Heart Problems,

Hypertension, Gout, Stroke, Fever, Cancer, Bone Disease, History of Stomach Ulcers,

Tuberculosis, Glaucoma, Cataracts, or No Medical Problems.

Surgeries and Dates

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