Abundant Life Family Medicine

HEALTH HISTORY QUESTIONAIRE

Please complete before seeing your Health Care Professional

Name____ Date__________________

Sex M F DOB____________________________ Age__________________

Major Health Problem(s)

1.____

2.____

3.____

Regular Medications (Name, dosage, and frequency including prescription, over-the-counter, vitamins, etc. Attach separate sheet of paper if more room is needed.)

____ ____

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Allergies

Medications (include type of reaction)	Other (food, other substances)
____	____
____	____
____	____

Family History

	Family Member(s)		Family Member(s)
High Blood Pressure	_____________________	Heart Disease	______________________
Diabetes	_____________________	Cancer	______________________
Liver Disease	_____________________	Kidney Disease	______________________
Asthma/Emphysema	_____________________	Stomach Trouble	______________________
Neurologic Disease	_____________________	Arthritis	______________________
Other	_____________________	Other	______________________

Procedures/Surgeries (Include dates and facility. Attach separate sheet of paper if more room is needed.)

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