Health History Questionnaire

Name____Date of Birth_______________

Daytime Phone_________________________________Evening Phone__________________________

Have you been hospitialized, other than childbirth, at least overnight for any reason? NO

If YES: Date(s) and Reason:____

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Have you had any surgery? NO

If YES Date(s) and Reason: ____

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Do you have any chronic or significant medical conditions? NO

If YES ____

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Please list your medications, prescriptions, vitamins, over-the-counter and herbal supplements:

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Have you had a colonoscopy, upper endoscopy, treadmill or other special diagnostic tests? NO

If YES Date and Type____

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Do you have allergies or reactions to any medications? NO

If YES Please explain:____

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