Renovation Health and Wellness
Health History Questionnaire

Patient's Name: _____ Date of Birth: _____

Today's Date: _____

Most Recent Physician: _____ Date of Last Exam: _____

What is the reason for your visit today? _____

Please list all medications being taken below:

Medication (Name, Strength, Dose Frequency)	Condition being treated:	Refill Needed?

Are you currently pregnant or nursing? _____

Please list any medication allergies.

Medication	Reaction (rash, itching, nausea, etc.)

Previous surgeries: _____

Previous Injuries requiring Medical Care: _____

_____

Do you smoke? Yes ___ No ___ If no, have you ever smoked? Yes ___ No ___

When did you quit? _____

Do you drink alcohol? Yes ___ No ___

Have you ever been told to cut down or quit alcohol? Yes ___ No ___

In your opinion, are you in Good ___, Fair ___, or Poor ___ health?

Is your energy level Normal ___, or below Normal ___?

Is your weight About Right ___, Too Heavy ___ or Too Light ___ ?

<u>Family History</u>:

Have any members of your immediate family (parents, siblings, grandparents, children) ever had the following: (please list relationship)

Breast Cancer? _____ Colon Cancer? _____

Other types of cancer? _____ High blood pressure? _____

Stroke? _____ Heart problems? _____

Diabetes? _____