

Date:

Name:

Age:

Height :

Weight:

Allergies:

Primary Care Physician:

HEALTH HISTORY QUESTIONNAIRE

Have you ever smoked? If so, Please circle:

Smoker (packs per day) (years of smoking) (have you ever smoked?)	yes	no

Diabetic Do you take insulin?	yes	no

Elevated cholesterol	yes	no

Hypertension (high blood pressure) Are you currently taking high blood pressure medication:	yes	no

Stroke or TIA	yes	no

Renal Failure (any problems with liver or kidneys)	yes	no

Pulmonary Diseases	yes	no

Recent Respiratory Infections	yes	no

Varicose Veins	yes	no

Anyone in your family with heart disease?	yes	no

(over)
