MEDICAL HISTORY QUESTIONNAIRE

Name: D.O.B Date:

Age: _____ Sex: M F

Reason for today's visit: _____

What are your health goals:_____

Occupation: _____

Marital Status: Single Married Widowed Divorced Number of Children: _____

With whom do you live? _____

Health problems you are being treated for: _____

_____

Physicians' Name, Address, Phone: _____

_____

Current Medications & Supplements:

Name	Dosage (mcg, mg, etc)	Directions	How Long?

Major Hospitalizations & Surgeries: _____

Circle the level of stress you are experiencing on a scale of 1-10. 1 2 3 4 5 6 7 8 9 10

Identify the major causes of your stress (i.e. job, home life, children, spouse, finances, legal):

_____