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HEALTH QUESTIONNAIRE

Name _____ Age _____ Height _____ Weight _____

Occupation _____

Reason for Visit _____

MEDICAL HISTORY

Major Surgery:

Serious Illness:

Major Injuries (Fractures):

Allergies:

Eye or Visual Problems:

Ear or Hearing Problems:

Bleeding Disorders:

Skin Disease:

Keloids:

Lung Trouble:

Heart Trouble:

Kidney or Urine Problems:

Epilepsy or Convulsions:

Migraine Headaches:

Psychiatric Care:

Smoke and/or Nicotine use:

Alcohol:

Medications:

TREATING PHYSICIANS:

FAMILY MEDICAL HISTORY

Any family members with the following?

Diabetes:

Tuberculosis:

Cancer:

Heart Disease:

REFERRED BY:

Doctor:

Advertisement:

Internet:

Web Site (www.drwethe.com):

Friend:

Signature _____

Date _____