HAKSHA
HEALTHCARE S.C

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PATIENT HISTORY

Date Today:

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ Male ☐ Female	**DOB:**	/ /
Marital status:	☐ Single ☐ Married ☐ Male Partner ☐ Female Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married			
Employment:	☐ Retired ☐ Full- Time ☐ Part-Time ☐ Unemployed ☐ Self Employed ☐ Military ☐ Homemaker			
Education:	☐ High School ☐ Undergraduate ☐ Graduate ☐ Doctorate	Other:		
Religion:		**Living With:**	☐ Alone ☐ Spouse ☐ Significant Other ☐ Family ☐ Friends	
Travel:	☐ None in last six months ☐ Travels to South Africa ☐ Travels to Europe ☐ Travels to Asia ☐ Travels to Africa			
Occupational Exposure:	☐ None ☐ Toxic Chemicals ☐ Noise Exposure ☐ Infectious Agents ☐ Repetitive Physical Stress			
Domestic Violence:	☐ None ☐ History in Past ☐ Have Restraining Order ☐ Feels unsafe at home ☐ Have safety plan			

PERSONAL HEALTH HISTORY

Primary Care Physician:	**Ph #:**
Referring Physician :	**Ph#:**

List your prescribed drugs and over the counter drugs, such as vitamins and inhalers:

Name of Drug	Strength	Frequency Taken

List your Allergies to Medications:

Name of Drug	Reaction You Had	Name of Drug	Reaction You Had