

# HEALTH HISTORY QUESTIONNAIRE

Date: \_\_\_\_\_

1208B VFW Parkway Suite 201  
Boston MA 02132  
Tel:617.327.1812  
[www.sunudang.com](http://www.sunudang.com)

## General Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth:        /        /        Age:        Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Occupation: \_\_\_\_\_ Name of Company: \_\_\_\_\_

## Insurance Information

Primary Health Insurance: \_\_\_\_\_ Member ID# \_\_\_\_\_

Subscriber (Primary Insurer) Name: \_\_\_\_\_ Date of Birth:        /        / \_\_\_\_\_

Secondary Health Insurance: \_\_\_\_\_ Member ID# \_\_\_\_\_

Subscriber (Primary Insurer) Name: \_\_\_\_\_ Date of Birth:        /        / \_\_\_\_\_

## Reason for Visit

What is the reason for your visit today? How, when and where did this condition begin?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

What types of treatments have you tried, if any?

---

How does this condition impair your daily activities?

---

---

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Hospitalizations/Surgeries, Falls and Major Accidents (incl. Dates):

---

---

Any other medical conditions (for example, chronic diseases- diabetes, heart disease etc.):

---

---

Please list any **medications/vitamins/supplements** you are currently taking:

Medications

Reason

When & For how long

---

---

---

---

---

Herb/Medication **allergies** and reaction (if any): \_\_\_\_\_

---