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LIFE HISTORY QUESTIONNAIRE

Name:____ Date: __________________

Home #:_________________ Work #:__________________ Cell #: ________________

Address: ____________________________ City:_____________State:____ Zip:_______

Email Address:_____________ ____

Age:_____ Date of Birth: _______________ Birthplace: ___________________________

Occupation:_________________________________ SS#:____________________________

Employer:_____________________________ Religious Affiliation: __________________

Marital Status: (circle one)

Single Married Separated Divorced Widowed Remarried

Household Members, their relationship to you, their age? __________________________

____

Health during Childhood:____

Health during Adolescence: ____

Doctor and date of last physical exam: ____

State in your own words the nature of your main problems and their duration: _________

____

____

AUTHORIZATION FOR RELEASE OF INFORMATION

This is to authorize ____

to release any information regarding ____

to ____

I understand that this information will be kept confidential.

____
Patient's Signature

____
Print Name

____
Date

Questionnaire - Life History
Modified 8/2007