Health History Questionnaire

Important: Complete this questionnaire as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but may play a major role in diagnosis and treatment. All the information that you provide in this questionnaire is strictly confidential and will become part of your medical record.

Date:_____

Patient Information

Patient Name	
Sex	
Date of Birth: (mm/dd/yyyy)	
Age	
Country	
Email Address	
Relationship Status	
Current Occupation	
Contact Number	
Name & Contact Number of Family Member (mention here the name & contact number of a person for emergencies)	
Hostel/Hotel Address	
Type of Retreat	
