NEW YORK INSTITUTE OF TECHNOLOGY
COLLEGE OF OSTEOPATHIC MEDICINE

ACADEMIC HEALTH CARE CENTER
Northern Blvd, Old Westbury, NY 11568
(516) 686-1300 Fax: (516) 686-7890

FAMILY HEALTH CARE CENTER-CI
267 Carleton Ave, Central Islip, NY 11722
(631) 348-3254 Fax: (631) 348-3031

HEALTH QUESTIONNAIRE
PLEASE PRINT

To be completed by the patient (or care giver):

NAME: ____ DATE: ________________

DATE OF BIRTH: ______________________________ AGE: __________________

HEIGHT: _________ WEIGHT: ________________________ SEX: M __ F __

DRUG ALLERGIES: ____

Reason for today's visit? Please list in order of importance present health concerns, symptoms, or problems you are experiencing. ____________________________________

____

____

Are your complaints related to either of the following?

Motor Vehicle Accident/No-Fault Claim?	**Yes**	**No**
Work-Related Injury/Worker's Compensation Claim?	**Yes**	**No**

If related to either of the above, please notify our front desk.

Medications	Dosage	Times/Day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

I am not currently taking any medication □

____ ________________________________

PATIENT SIGNATURE DATE

OR – IF FORM WAS COMPLETED BY CARE GIVER

____ ________________________________

CARE GIVERS NAME (PRINTED) & SIGNATURE DATE

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RELATIONSHIP TO PATIENT

FORM #101