HEALTH HISTORY FORM

Date: _____

Patient Name: _____

Date of Birth: _____ Age: _____

Previous Physician: _____

Previous Physician Phone #: _____

HEALTH BEHAVIORS

☐ Yes ☐ No **Do you smoke?** Quantity _____ per day / week / month

☐ Yes ☐ No **Do you drink alcohol?** Quantity _____ per day / week / month

☐ Yes ☐ No **Do you use any addicting substances?** Specify _____

☐ Yes ☐ No **Do you exercise?** Frequency _____ per day / week / month

FAMILY MEDICAL HISTORY

Does any member of your family have the following diseases/conditions?

If yes, please explain:

☐ Yes ☐ No **Heart Disease** _____

☐ Yes ☐ No **Cancer** _____

☐ Yes ☐ No **Asthma** _____

☐ Yes ☐ No **Diabetes** _____

☐ Yes ☐ No **High Blood Pressure** _____

☐ Yes ☐ No **Depression/Mental Illness** _____

☐ Yes ☐ No **Liver Disease** _____

☐ Yes ☐ No **Blood Disorder** _____

☐ Yes ☐ No **Tuberculosis** _____

☐ Yes ☐ No **Alcoholism** _____

☐ Yes ☐ No **Substance Abuse** _____

☐ Yes ☐ No **Thyroid Disease** _____

☐ Yes ☐ No **Kidney Disease** _____

☐ Yes ☐ No **Osteoporosis** _____

Please give current health status of the following family members:
(If deceased, indicate age, and cause of death)

Father _____

Mother _____

Sister(s) _____

Brother(s) _____

Father's Relatives _____

Mother's Relatives _____

WOMEN ONLY

_____ Date of onset of last menstrual period

_____ Date of last Pap smear or pelvic exam

_____ Date of last mammogram

_____ Number of pregnancies

_____ Number of pregnancies carried to term

☐ Yes ☐ No **Do you have a gynecologist?**

☐ Yes ☐ No **Would you like us to provide gynecologic care?**

☐ Yes ☐ No **Have you ever had gestational diabetes** (during pregnancy)**?**

VACCINATIONS

Have you received the following vaccinations? DATE

☐ Yes ☐ No **Tetanus booster** _____

☐ Yes ☐ No **Influenza** _____

☐ Yes ☐ No **Pneumonia** _____

☐ Yes ☐ No **Chicken Pox** _____

ALLERGIES

List (or attach) all medication allergies/sensitivities & reactions:

_____

_____

MEDICATIONS

List (or attach) all medications you are presently taking, including any OTC or natural products:

Medication	Strength (mg)	Dosage per day

CURRENT HEALTH PROBLEMS

List (or attach) all conditions for which you currently receive medical care:

Problem	Date of Onset

PREVIOUS MEDICAL HISTORY

List (or attach) all previous hospitalizations, operations, and prior health problems (include name of hospital if available):

Year	Problem	Outcome

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