Health History Form

Please complete the following form to the best of your ability. **Your answers are for our records only and will be kept confidential.** Your answers will help your provider better understand your medical concerns. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important.

Full Patient Name   Patient Date of Birth (MM/DD/YYYY)

Main reason for today's visit:
Other concerns:

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

Allergy	Reaction	Allergy	Reaction
1. ___	___	3. ___	___
2. ___	___	4. ___	___

Your preferred Pharmacy: ___ Address: ___

Please list all the medications you are currently taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Please Check All That Apply to Your Past Medical History

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood clots (or DVT)
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Claustrophobia
- ☐ Diabetes — Insulin
- ☐ Diabetes — Non-insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Has Pacemaker
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hiatal Hernia or Reflux Disease
- ☐ HIV or AIDs
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Overactive Thyroid
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Reflux or Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other ___

Past Surgical History

SURGERY	REASON	YEAR	HOSPITAL
1.			
2.			
3.			
4.			

Obstetric and Gynecological History, if Applicable

Last Pap Smear Date: ___ ☐ Abnormal
Last Mammogram Date: ___ ☐ Abnormal
Number of pregnancies: ___
Number of miscarriages: ___
Cesarean sections (yes/no): ___

Age of first menstrual period: ___
Date of last menstrual period or age of menopause: ___
Number of births: ___
Number of abortions: ___
If yes, number of cesarean sections: ___

Family Health History

RELATION	ALIVE? (Y/N)	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)			☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (maternal)			☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandmother (paternal)			☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (paternal)			☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Father			☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Mother			☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister			☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister			☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Other: ____________			☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke

Social Health History

Please check below all that apply to your tobacco, alchohol, and caffiene intake, if any:

☐ Never smoked ☐ Former smoker ☐ Current smoker ☐ Decline to answer Years of tabacco use: ____________________

☐ 1 pack/week ☐ 2 packs/week ☐ 1/4 pack/day ☐ 1/2 pack/day ☐ 1 pack/day ☐ 1 1/2 packs/day ☐ 2 packs/day ☐ 3+ packs/day

☐ Never used smokeless tabacco ☐ Former smokeless tabacco user ☐ Current snuff user ☐ Currently chews tabacco ☐ Currently uses moist powdered tabacco ☐ Decline to answer

☐ Never used electronic cigarettes ☐ Former user of electronic cigarettes ☐ Current user of electronic cigarettes ☐ Decline to answer

Caffeine intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Alcohol intake: ☐ Yes ☐ No

If yes, how many drinks/week? ____________

Do you use any illicit or recreational drugs? ☐ Yes ☐ No **Which kind?** ____________

Are you currently employed? ☐ Yes ☐ No **Occupation:** ____________________

College Degree Acheived: ☐ Yes ☐ No **Degree Type** ____________ **Currently in School:** ____________

	Yes	No
Are you able to care for yourself?		
Are you legally blind in one or both eyes?		

	Yes	No
Are you hard of hearing or deaf in one or both ears?		

Marital Status: ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Single ☐ Domestic Partner

Please check below all that apply to you:

Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Sexually Active? ☐ Yes ☐ No

Diet: ☐ Regular ☐ Vegitarian ☐ Diabetic ☐ Gluten Free ☐ Specific ☐ Cardiac

Do you use an advanced directive? ☐ Yes ☐ No