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HEALTH HISTORY FORM

Today's Date: _____

Patient's Name: _____ Date of Birth _____/_____/_____

Past Medical History: Have you ever had any of the following, check all that apply

□Alcoholism
□Anemia
□Arthritis
□Anxiety
□Asthma
□Blood Transfusion
□Blood Clot
□Cancer
□Cataract
□Depression
□Diabetes
□GERD
□Glaucoma
□Headache
□Heart Problem
□Hepatitis
□Herpes
□High Blood Pressure
□High Cholesterol
□HIV
□Kidney Disease
□Liver Disease
□Osteoporosis
□Prostate Problem
□Seizure
□Skin Problem
□Stomach Ulcer
□Stroke
□Thyroid Disease
□Tuberculosis
□Other:
□Other:
□Other:

Past Surgical History: Please list all surgeries and dates of the surgery

_____ _____

_____ _____

_____ _____

Hospitalizations:_____

Allergies: please list all

_____

Medications: please include medication name, dosage and how frequently taken

Name	Dosage

Family History :

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
High Blood Pressure						
High Cholesterol						
Diabetes						
Heart Disease						
Stroke						
Cancer						
Asthma						
Seizures						
Kidney Disease						
Thyroid Disease						
Bleeding Disorders						
Deceased? (cause of death/age of death)						
Other (please specify)						

Social History:
Occupation: _____
Marital Status: □Single □Married □Divorced □Separated □Widowed
Drink Caffeine? □No □Yes, _____cups/day
Tobacco Use? □Never □Not now, when quit?_____ □Yes, _____packs/day
Drink Alcohol? □No □Yes, _____drinks/day
Use recreational drugs? □Never □Not Now □Yes, drugs used_____
Sexually active? □Virgin □Not sexually active □Yes, one partner □Yes, multiple partners
Sexual orientation? □ Heterosexual (sex with opposite sex) □Homosexual (sex with same sex) □Bisexual (sex with both sexes)
Do you Exercise? □No □Yes, type of exercise and frequency _____
Do you wear a seatbelt? □No □Yes
Do you have a smoke detector in your home? □No □Yes
Do you have firearms in your home? □No □Yes
Do you use sunscreen regularly? □No □Yes
Do you perform self breast exams/self testicular exams? □No □Yes
Do you wear a bike helmet? □No □Yes
Have you had any recent falls? □No □Yes
Have you ever been abused? □No □Yes
Have you ever been involved in violence? □No □Yes
Do you have an Advance Directive or Living Will? □No □Yes

Vaccines: List the date when you last received:

Td/Tdap:	Influenza::
Prevnar 13:	Zostavax/Shingrix:
Pneumovax 23:	Covid:

Preventative: Have you had any of these procedures done, if yes, when was your last exam?

Last Mammogram:	Last Colonoscopy:
Last PAP:	Last Dental Exam:
Last Dexa bone density:	Last Eye Exam:

Other Problems/Symptoms: please circle all that apply

General:	Weight loss	Weight gain	Chills	Fever	Other:		
Eyes:	Decreased vision	Double vision	Eye Pain	Dryness	Other:		
Ear/Nose/Throat:	Decreased hearing	Difficulty swallowing	Dizziness	Sinus	Hoarseness	Other:	
Heart/Circulation:	Chest pain	Palpitations	Shortness of breath w/ exertion	Other:			
Lungs:	Cough	Wheezing	Shortness of breath	Other:			
Stomach/Intestine:	Abdominal pain	Blood in stool	Change in bowels	Nausea	Vomiting	Diarrhea	Other:
Bladder/Kidney:	Pain with urinating	Blood in urine	Incontinence	Frequency			
Bone/Joint/Muscle:	Back pain	Neck pain	Joint pain	Muscle pain			
Skin & Breast:	Rash	Change in moles	Lumps	Cancer			
Neurological:	Seizures	Numbness	Tingling	Tremor	Headaches	Memory Loss	Other:
Psychiatric:	Anxiety	Depression	Eating disorders	Sleep problems	Thoughts of suicide		
Endocrine:	Cold intolerance	Heat intolerance					
Blood Cells:	Abnormal bleeding	Abnormal bruising	Enlarged lymph nodes	Anemia			
Allergy/Immunity:	Bee allergy	Food allergy	Seasonal allergy	Medication allergy	Hives	Other:	

Other physicians currently treating you: _____

_____

_____

_____

_____

Other information you would like your doctor to know: _____

_____

Patient/Guardian Signature: _____ Date: _____