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Today's Date: ____________________

Name: ____ Birthdate Date: ________________ Gender: M F

Are you: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Currently Living: ☐ Alone ☐ With Family ☐ With Friends ☐ With Significant Other

Working? ☐ Yes ☐ No Employed By: ____ ☐ Retired?

HEALTH HISTORY

Mark (x) all items either No or Yes	No	Yes, Now	Yes, Past	Mark (x) all items either No or Yes	No	Yes, Now	Yes, Past
Abnormal EKG				Headaches (Frequent)			
Alcoholism				Heart Attack or Heart Disease			
Anemia or Low Blood				Heart Murmur			
Anxiety				Hemorrhoids or Rectal Problems			
Arthritis or Sore Joints				Hepatitis Type A, B or C (circle)			
Asthma or Hay Fever				Hernia			
Bleeding or Bruising				High Blood Pressure			
Broken Bones				High Cholesterol			
Bronchitis or Emphysema				HIV/AIDS			
Cancer				Jaundice			
Cataracts				Kidney or Bladder Problems			
Chemical Dependency				Leg or Foot Pain or Swelling			
Chest Pain				Liver Disease			
Circulation Problems				Night Sweats			
Deafness, Dizziness or Ringing Ears				Phlebitis or Blood Clots			
Depression or Sadness				Psychiatric Care			
Diabetes				Sexually Transmitted Disease			
Difficulty Sleeping or Lie Awake				Shortness of Breath			
Ear Infections				Sinus Trouble			
Epilepsy or Seizure				Skin Disease, Psoriasis or Eczema			
Fatigue or Tiredness or Weakness				Stomach Problems or Ulcers			
Forgetful				Stool or Bowel Problems			
Gall Stones				Stroke			
Glaucoma				Thyroid Problem			
Gout				Tuberculosis or Positive TB Test			
Head Injury				Weight Loss or Gain (circle one)			

HABITS/MEDICATIONS

Do you:		If YES, how much?	Do you:		If YES, how much?
Smoke Tobacco	☐ No ☐ Yes	Packs/Day	Drink Beer	☐ No ☐ Yes	Cans/Day
Chew Tobacco	☐ No ☐ Yes	Tins, Bags/Day	Gamble	☐ No ☐ Yes	Times/Month
Drink Caffeine	☐ No ☐ Yes	Cups/Day	Use Street Drugs	☐ No ☐ Yes	Daily/Weekly
Drink Alcohol or Wine	☐ No ☐ Yes	Drinks/Day	Exercise	☐ No ☐ Yes	Daily/Weekly

Medication	Strength	Directions	Medication	Strength	Directions
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

IMMUNIZATIONS

Flu Shot	☐ No ☐ Yes	Date	Pneumonia	☐ No ☐ Yes	Date
Hepatitis	☐ No ☐ Yes	Date	Shingles	☐ No ☐ Yes	Date
MMR	☐ No ☐ Yes	Date	Tetanus	☐ No ☐ Yes	Date

ALLERGIES

1.	Reaction:	4.	Reaction:
2.	Reaction:	5.	Reaction:
3.	Reaction:	6.	Reaction:

SURGERIES/ HOSPITALIZATIONS/ SERIOUS ILLNESSES

1.	Year:	4.	Year:
2.	Year:	5.	Year:
3.	Year:	6.	Year:

FAMILY HISTORY

Mark (X) either No or Yes. If Yes, please mark **(X)** the family Member who has (or in the past had) Any of the medical problems listed.		Father	Mother	Brother	Sister	Son	Daughter	Grandparent
Alcoholism	☐ No ☐ Yes							
Allergies	☐ No ☐ Yes							
Anemia	☐ No ☐ Yes							
Arthritis	☐ No ☐ Yes							
Asthma or Hay Fever	☐ No ☐ Yes							
Birth Defects	☐ No ☐ Yes							
Blood Clots	☐ No ☐ Yes							
Cancer	☐ No ☐ Yes							
Colon or Bowel Problems	☐ No ☐ Yes							
Congenital Heart Defect	☐ No ☐ Yes							
Diabetes	☐ No ☐ Yes							
Emphysema	☐ No ☐ Yes							
Epilepsy	☐ No ☐ Yes							

Mark (X) either No or Yes. If Yes, please mark **(X)** the family Member who has (or in the past had) Any of the medical problems listed.		Father	Mother	Brother	Sister	Son	Daughter	Grandparent
Heart Disease	☐ No ☐ Yes							
High Blood Pressure	☐ No ☐ Yes							
Kidney Disease	☐ No ☐ Yes							
Leukemia	☐ No ☐ Yes							
Liver Disease	☐ No ☐ Yes							
Mental Illness	☐ No ☐ Yes							
Migraines	☐ No ☐ Yes							
Nervous Breakdown	☐ No ☐ Yes							
Obesity	☐ No ☐ Yes							
Rheumatic Fever	☐ No ☐ Yes							
Sickle Cell Anemia	☐ No ☐ Yes							
Stomach Issues or Ulcer	☐ No ☐ Yes							
Stroke	☐ No ☐ Yes							

MEN ONLY

Prostate disease or problems?	☐ No ☐ Yes
Problems starting/stopping urine stream?	☐ No ☐ Yes
Wake in the night to use the bathroom?	☐ No ☐ Yes
Do you feel safe in your home?	☐ No ☐ Yes
Date of last PSA level?	
Date of last Colonoscopy?	

WOMEN ONLY

Last Pap Smear Date:	Abnormal?	☐ No ☐ Yes
Last Mammogram Date:	Abnormal?	☐ No ☐ Yes
Wake in the night to use the bathroom?		☐ No ☐ Yes
Ovarian Cysts?		☐ No ☐ Yes
Breast Disease?		☐ No ☐ Yes
Date of last Colonoscopy?		
Date of last Bone Density Scan (DEXA)		

THE INFORMATION PROVIDED ON THIS PATIENT HEALTH HISTORY IS CORRECT TO THE BEST OF MY KNOWLEDGE

Patient or Guardian Signature: ______________________________ Date: ______________

Physician Signature: ______________________________ Date: ______________

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