HEALTH HISTORY

(Confidential)

Height_____ Wt_____

Name_____ Today's Date_____

Primary Care Physician_____ Date of Last Physical Examination_____

What is your reason for today's visit?_____

1. CONDITIONS Check (✓) symptoms you currently have or have had in the past year.

___ AIDS	___ Goiter	___ Pacemaker
___ Alcoholism	___ Gout	___ Pneumonia
___ Anorexia	___ Heart Disease	___ Polio
___ Appendicitis	___ Hepatitis	___ Prostate Problem
___ Arthritis	___ Hernia	___ Psychiatric Care
___ Asthma	___ Herpes	___ Rheumatic Fever
___ Bleeding Disorders	___ Hiatal Hernia	___ Scarlet Fever
___ Breast Lump	___ High Blood Pressure	___ Stroke
___ Bronchitis	___ High Cholesterol	___ Suicide Attempt
___ Cancer	___ HIV Positive	___ Thyroid Problems
___ Cataracts	___ Kidney Disease	___ Tonsillitis
___ Chemical Dependency	___ Liver Disease	___ Tuberculosis
___ Chicken Pox	___ Measles	___ Typhoid Fever
___ Diabetes	___ Migraine Headaches	___ Ulcers
___ Emphysema	___ Miscarriage	___ Vaginal Infections
___ Epilepsy	___ Mononucleosis	___ Venereal Disease
___ Gastro esophageal Reflux	___ Multiple Sclerosis	Are you pregnant?_____
___ Glaucoma	___ Mumps	Number of children?_____

2. MEDICATIONS List medications your are currently taking	**3. ALLERGIES** To medications or substances

Pharmacy Name_____ Phone_____

4. FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Mother				
Father				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

5. HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates:_____

SERIOUS ILLNESS/INJURY	DATE	OUTCOME

6. PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any:

7. HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

8. OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

	Stress
	Heavy Lifting
	Hazardous Substances
	Other

Your Occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors of omissions that I may have made in the completion of this form.

Signature _____ Date _____

Reviewed By _____ Date _____