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Health History Form

IDENTIFICATION

First Name __________________ Last Name _______________________ Date of Birth _____________

Address ____

Phone #1 __________________________________ Phone #2 _____________________________________

Referred by ____

Previous Primary Care Doctor ____

SPECIALISTS THAT YOU CURRENTLY SEE

____

____

____

____

____

PLEASE DESCRIBE THE REASON FOR YOUR VISIT

____

____

____

____

____

ALLERGIES TO MEDICATIONS (please describe what happened when you took this medication)

____

____

PRESCRIPTION MEDICATIONS

Name Strength How many times daily AM/PM

____

____

____

____

____

____

____

____

____

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HERBAL MEDICATIONS OR VITAMINS

____

____

CHRONIC MEDICAL CONDITIONS (PLEASE CIRCLE ALL THAT APPLY)

Asthma	Allergies	Arthritis	Anxiety
Acid reflux/GERD	Anemia	Atrial fibrillation	Barrett's esophagus
Blood disorder	COPD/emphysema	Cancer	Depression
Diabetes	Heart Disease	High blood pressure	High cholesterol
HIV	Kidney disease	Liver disease	Sinus infections
Seizure disorder	Stomach ulcer	Tuberculosis	Thyroid problem

Other ____

SURGERIES (year):

____

____

____

____**H**

OSPITALIZATIONS (what hospital, for what problem, and year):

____

____

____

HEALTH MAINTENANCE YOU MAY HAVE HAD (year completed):

Tetanus vaccination ________________________

Pertussis (whooping cough) vaccine ________________________

Flu Shot ________________________

Pneumonia vaccine ________________________

Shingles vaccine ________________________

Mammogram ________________________

Bone scan ________________________

Colonoscopy _______________ Sigmoidoscopy ______________ or Stool card ________________

TOBACCO HISTORY

Do you currently smoke? _____________ How many packs or cigarettes daily? ___________________________

Did you ever smoke? ________________ At your heaviest consumption, how many packs daily? ____________

How old were you when you started? ____________ How old were you when you quit? _______________

ALCOHOL INTAKE

Do you drink alcohol? ___________ Circle: **daily** **weekly** **monthly** **very rarely**

On average, how many beers, glasses of wine, or drinks at a time? ____

OTHER SUBSTANCE USE

Do you currently use illicit substances? ___________ Have you ever in the past? _______________________

EXERCISE

What kind of sustained (>20 min at a time) exercise do you do? ____

____

How often? ____

CURRENT OR PREVIOUS OCCUPATIONS ____

FAMILY HISTORY

Relative	Age if living	Age when deceased	Medical problems
Mother			
Father			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			

FOR WOMEN ONLY

Name of GYN ______________________________________ Date of last period ______________________________

Age at onset of menopause __________________________ How many pregnancies? ______ Births? _____

Have you ever had a miscarriage? ____________________ In which trimester? ____________________________

Year of last pap smear _______________________________ Have you ever had an abnormal pap? ____________