Health History

Date: _____

Name: _____ **Date of Birth:** _____ **Sex:** ☐ M ☐ F

Preferred Phone _____ ☐ H ☐ C ☐ W **Alternate Contact Phone** _____ ☐ H ☐ C ☐ W

Emergency Contact _____ **Relationship:** _____ **Phone** _____

Referring Doctor: _____ **Address:** _____ **Phone** _____

Allergies to Medications, X-Ray Dyes, Latex, Tape or Other Substances	Reaction

Current Medications (Prescription, Over the Counter, Vitamins, Herbs, etc.) **Please bring medication bottles with you to your appointment.**

Drug Name and Dose	Frequency	Drug Name and Dose	Frequency
1)		4)	
2)		5)	
3)		6)	

Surgeries and Hospitalizations

Surgery/Procedure Type	Date	Hospitalization Reason	Date
1)		1)	
2)		2)	
3)		3)	

Medical History

Please indicate if you have had problems with (**Past**), current (**Current**), or never (**Never**) any of the following:

P	C	N		P	C	N		P	C	N		P	C	N	
			AIDS/HIV				Deep Vein Thrombosis				High Cholesterol				Skin Disease
			Amputations				Eating Disorder				Irritable Bowel Syndrome				Stroke
			Anemia				Epilepsy				Kidney Disease				Suicide Attempt
			Anxiety				GERD/Ulcer Disease				Kidney Stones				TB/Positive PPD
			Appendicitis				Glaucoma				Liver Disease				Thyroid Problems
			Arthritis				Gout				Migraine Headaches				Vascular Disease
			Asthma				Hay Fever				Multiple Sclerosis				Other:
			Bipolar Disorder				Heart Disease				Neuropathy				1.
			Bleeding Disorders				Heart Murmur				Pacemaker				2.
			Blood Disorders				Hemorrhoids				Rheumatic Fever				3.
			Cancer				Hepatitis				Seizures				
			COPD/Emphysema				High Blood Pressure				Sexual Transmitted Disease				

Family History

Has any member of your family (including parents, grandparents and siblings) ever had the following?

Illness	Which Family Member	Approximate Age When Diagnosed	Living or Deceased
Cancer (describe type)			
Diabetes			
Drug or Alcohol Addiction			
Heart Disease			
Hyperlipidemia			
Hypertension (high blood pressure)			
Mental Disease (anxiety, depression, etc.)			
Stroke			
Other:			

Health History

Patient Name: **Date of Birth:**

Review of Medical Symptoms

Please indicate if you have had problems with (**P**ast), current within the past 30 days (**C**urrent), or never (**Never**) any of the following:

P	C	N		P	C	N		P	C	N		P	C	N	
			Abdominal Pain				Difficulty Urinating				Hoarseness				Poor Circulation
			Bloating/Gas				Dizziness				Indigestion				Rash
			Blood in Stool				Earache				Itching				Ringing in Ears
			Blood in Urine				Excessive Thirst				Lack of Bladder Control				Shortness of Breath
			Bruise Easily				Fainting				Lightheadedness				Sinus Problems
			Change in Bowel Habits				Fever				Nausea				Sore That Won't Heal
			Change in Moles				Forgetfulness				Nervousness				Swollen Ankles
			Change in Vision				Frequent Urination				Night sweats				Unexplained Wt Loss/Gain
			Chest Pain				Hair Loss				Nosebleeds				Vomiting
			Chills				Hearing Loss				Painful Urination				Other:
			Constipation				Headache				Palpitations/Irregular Heartbeat				1.
			Depression				Hemorrhoids				Persistent Cough				2.
			Diarrhea				Hives				Poor Appetite				3.

Social History Please indicate if you have in the (**Past**), current (**Current**), or never (**Never**) any of the following:

	P	C	N	
Do you smoke?				If past or current, how many packs per day? How many years?
Do you drink alcoholic beverages?				If past or current, how much per week?
Caffeine usage?				If past or current, how many cups per day?
Have you ever worked with chemicals, paints, asbestos or other hazardous materials?				If yes, please explain:
Do you follow any specific diet?	**Yes**		**No**	If yes, please explain:
Do you exercise on a regular basis?	**Yes**		**No**	If yes, please explain:

Prevention

	Yes	No	
Do you wear seat belts?			If no, why not?
Do you wear a bike helmet?			
If there is a gun in your home, do you keep unloaded and out of children's reach?			
Have you ever engaged in any activity which has put you at risk of getting a sexually transmitted disease?			If yes, explain:
Do you wish to be tested for a sexually transmitted disease?			
Do you feel safe at home?			
Do you have smoke/carbon monoxide detectors in your home?			

Men's Health

Please indicate if you have had problems with (**P**ast), current within the past 30 days (**C**urrent), or never (**Never**) any of the following:

P	C	N		P	C	N		P	C	N		P	C	N	
			Breast Lump				Lump in Testicles				Sexually Transmitted Infection				Other:
			Erection Difficulties				Prostate Problem				Sore on Penis/Penile Discharge				

Sexual preference: _____

Women's Health

Please indicate if you have had problems with (**P**ast), current within the past 30 days (**C**urrent), or never (**Never**) any of the following:

P	C	N		P	C	N		P	C	N		P	C	N	**Date of Last:**
			Abnormal Pap Smear				Hot Flashes				Sexually Transmitted Infection				Mammogram:
			Abnormal Bleeding				Miscarriage				Vaginal Infections				Menstrual Period:
			Breast Lump				Nipple Discharge				Number of Children:				Pap Smear:
			Extreme Menstrual Cramps				Painful Intercourse				Are you Pregnant:	**YES**		**NO**	

Sexual preference: _____

Vaccinations

Please provide a record of all vaccinations if possible.

	Date		Date		Date		Date
DTAP		HPV		PPD		TDAP	
FLU		MENINGOCOCCAL		PREVNAR 13		VARICELLA	
HEP A		MMR		ROTOTEQ			
HEPB		POLIO		SHINGLES			
HIB		PNEUMOCOCCAL 23		TD			

I CERTIFY THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY DOCTOR OR ANY MEMBERS OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

Patient Signature Date

Review By Date