Health History

Personal Information

Date: _____

Name: _____

Sex: _____ Date of Birth: _____

Address: _____

City: _____ State:_____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Employment Information

Occupation: _____

Employer: _____

Employer's Address: _____

City: _____ State:_____ Zip Code: _____

Work Phone: _____

Emergency Contact

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

What is your main concern today?

____Checkup

____ Specific concern: _____

For Women Only

Are you pregnant now? _____ Yes ____ No

Have you been pregnant? _____ Yes ____ No

How many times? _____

How many children have you given birth to? _____

When was your last Pap test? _____

Have you had a Pap test that was not normal? _____ Yes _____ No

When? _____

Have you had a mammogram? _____ Yes _____ No

When? _____

What are your current main health concerns? (Check all persistent symptoms or conditions)

General

____ Unexplained weight gain/ loss

____ Fatigue

Skin

____ Mole

____ Eczema

Breast

____ Breast lump

____ Discharge

Ears/Nose/Throat

____ Nose bleeds

____ Loss of hearing

Cardiovascular

____ Chest pain

____ Palpitations

Respiratory

____ Loud snoring

____ Cough

Gastrointestinal

____ Heartburn

____ Constipation

Musculoskeletal

____ Back pain

____ Muscle/joint pain

Hematological/Lymphatic

____ Swollen glands

____ Easy bruising

Neurological

____ Headache

____ Memory loss

Psychiatric

____ Anxiety/Irritability

____ Lack of concentration

Women Only

____ Problems with menstrual cycles

____ Hot flashes

Medications

What prescription medications are you currently taking? (List the **name** of each medication and the **dose.**)

_____

_____

_____

What over-the-counter medicines do you take?

_____ Pain reliever (for example: Tylenol, Advil, Motrin, Aleve, aspirin)

_____ Antacid (for example: Tums, Prilosec)

_____ Vitamins or Herbal supplement (please list) _____

Allergic Reactions

Have you had an allergic reaction (bad effect) from a medicine? _____ Yes _____ No

If yes, please list the **name** of each medication and each **reaction.**

_____

_____

Health History

Have you been a patient in a hospital overnight? ____ Yes ____ No

If yes, **when** and **why** were you in the hospital?

_____

_____

Have you or a family member had any of the following conditions?

	You	Brother	Sister	Mother	Father	Maternal Grand-mother	Maternal Grand-father	Paternal Grand-mother	Paternal Grand-father	Don't Know
Alcoholism/ Drug Abuse										
Allergies										
Anemia										
Anxiety										
Arthritis										
Asthma										
Autoimmune Disease										
Cancer										
Coronary Heart Disease										
Depression										
Diabetes										
Eczema										
Glaucoma										
Hepatitis B or C										
High Cholesterol										
Hypertension										
Migraines										
Osteoporosis										
Seizure										
Stroke										
Tuberculosis-TB										

Social History

Circle the highest grade you finished in school:

1 2 3 4 5 6 7 8	9 10 11 12 GED	1 2 3	1 2 3 4+
Grade School	High School	Technical College	University

What language do you prefer to speak? _____

Do you smoke? _____ Yes _____ No

Do you want to quit? _____ Yes _____ No

Do you drink alcohol? _____ Yes _____ No

How many drinks do you have in one week? _____

How many drinks with caffeine (coffee or soda) do you have each day? _____

Do you exercise? _____ Yes _____ No

How many times a week do you exercise? _____

What type of exercise do you do? _____

Do you have a lot of stress? _____ Yes _____ No

How do you manage your stress?

_____

How many hours do you sleep at night? _____

Do you wear a seatbelt? ____ Yes _____ No

Do you have questions or other concerns about your health?

_____