Health History

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

Have you had a Pap test?_____ Yes ____ No

Medications

Do you take prescription medicine? _____ Yes _____ No

Do you take over-the-counter medicine? _____ Yes _____ No

Allergic Reactions

Have you had a bad reaction to a medicine? _____ Yes ____ No

Social History

What language do you prefer to speak? _____

Do you smoke? _____ Yes _____ No

Do you exercise? _____ Yes _____ No

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

How many hours do you sleep at night? _____

Do you wear a seatbelt? ____ Yes _____ No