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:

_____

What are your current main health concerns?

General	**Skin**	**Breast**
____ Fatigue	____ New mole	____ Breast lump
____ No problems	____ No problems	____ No problems

Ears/Nose/Throat	**Cardiovascular**	**Respiratory**
____ Loss of hearing	____ Chest pain	____ Cough
____ No problems	____ No problems	____ No problems

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

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

Health History 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										
Anxiety										
Arthritis										
Asthma										
Cancer										
Depression										
Diabetes										
Migraine										
Osteoporosis										
Tuberculosis (TB)										

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