

# HEALTH HISTORY

(Confidential)

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Date of last physical examination \_\_\_\_\_

Occupation \_\_\_\_\_

CONDITIONS Check (✓) conditions you have, or have had in the past.			
<input type="checkbox"/> AIDS	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Prostate Problem
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Anemia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anorexia / Bulimia	<input type="checkbox"/> Epilepsy / Seizures	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gout	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cataracts		<input type="checkbox"/> Polio	

Are you allergic to any medications? YES  NO  If Yes, which ones? \_\_\_\_\_

How often do you exercise a week? \_\_\_\_\_

Do you ever drink alcohol? YES  NO  If Yes, how many drinks per week? \_\_\_\_\_

Do you smoke? YES  NO  If Yes, how many packs per day? \_\_\_\_\_ For how many years? \_\_\_\_\_

If you quit, what year did you quit? \_\_\_\_\_

HOSPITALIZATIONS/SERIOUS ILLNESS OR SURGERY			PREGNANCY HISTORY		
Year	Hospital	Reason for Hospitalization and Outcome	Year of Birth	Sex of Birth	Complications If any

**FAMILY HISTORY -- Fill in health information about your family.**

Have any of your parents, brothers, sisters, children, aunts, uncles or grandparents had:

	NO	YES	If Yes, who?
Heart attack or angina before age 60?			
High Blood pressure?			
Stroke?			
Diabetes?			
High Cholesterol?			
Breast Cancer?			
Uterine or cervical cancer?			
Other cancer? (Specify)			
Seizures / Epilepsy?			
Mental Illness or Suicide?			
Heavy alcohol or drug use?			
Physical abuse?			
Sexual abuse?			
Asthma?			

I certify that 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.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_