HEALTH HISTORY
(Confidential)

Height________ Wt________

Name____Today's Date________________

Primary Care Physician____________________________Date of Last Physical Examination________________

What is your reason for today's visit?____

1. CONDITIONS Check (✓) symptoms you currently have or have had in the past year.

___ AIDS
___ Alcoholism
___ Anorexia
___ Appendicitis
___ Arthritis
___ Asthma
___ Bleeding Disorders
___ Breast Lump
___ Bronchitis
___ Cancer
___ Cataracts
___ Chemical Dependency
___ Chicken Pox
___ Diabetes
___ Emphysema
___ Epilepsy
___ Gastro esophageal Reflux
___ Glaucoma
___ Goiter
___ Gout
___ Heart Disease
___ Hepatitis
___ Hernia
___ Herpes
___ Hiatal Hernia
___ High Blood Pressure
___ High Cholesterol
___ HIV Positive
___ Kidney Disease
___ Liver Disease
___ Measles
___ Migraine Headaches
___ Miscarriage
___ Mononucleosis
___ Multiple Sclerosis
___ Mumps
___ Pacemaker
___ Pneumonia
___ Polio
___ Prostate Problem
___ Psychiatric Care
___ Rheumatic Fever
___ Scarlet Fever
___ Stroke
___ Suicide Attempt
___ Thyroid Problems
___ Tonsillitis
___ Tuberculosis
___ Typhoid Fever
___ Ulcers
___ Vaginal Infections
___ Venereal Disease

Are you pregnant?________

Number of children?______

2. MEDICATIONS List medications your are currently taking	**3. ALLERGIES** To medications or substances

Pharmacy Name____ Phone________________

4. FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Mother				
Father				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following:

Check	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

5. HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates:______________________________

SERIOUS ILLNESS/INJURY	DATE	OUTCOME

6. PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any:

7. HEALTH HABITS Check (✓) which substances you use and describe how much you use.

Check	Substance	Description
	Caffeine	
	Tobacco	
	Drugs	
	Other	

8. OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

Check	Concern
	Stress
	Heavy Lifting
	Hazardous Substances
	Other

Your Occupation:

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 staff responsible for any errors of omissions that I may have made in the completion of this form.

_______________________________ _______________ _______________________________ _______________

Signature Date Reviewed By Date