

HEALTH HISTORY (CONFIDENTIAL)

Name: _____ Today's Date: _____

Date of Birth: _____ Primary Care Physician: _____

Reason for Visit: _____

Medication: List all medications, prescription & non-prescription	Dose/Strength	# of pills/amts	Times/day

Medical History (Check (☑) conditions you have or have had in the past)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Received blood transfusion | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mental Condition: _____ | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Cancer of _____ | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Stomach/Intestinal Problems | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Other: _____ |

Allergies **ARE YOU ALLERGIC TO LATEX?** No Yes if yes, reaction _____

Allergy (Medication or Environmental)	Reaction

Gynecological History

Age when you started having periods: _____ Date of Last Menstrual Period: _____

Date of Last Pap Smear: _____ Result: _____

Date of Last Mammogram: _____ Result: _____

List any gynecological problems in past (i.e. endometriosis, breast lump, irregular periods, heavy bleeding, chronic pelvic pain) _____

Obstetrical History (Please fill out for each pregnancy even if it was a miscarriage or abortion.)

Type of Delivery (Miscarriage, Abortion, Vaginal Delivery, C-Section)	Date	Complications	Age

Surgical & Hospitalization History

List Type of Surgery or Reason for Hospitalization	Month/Year of Surgery

Family Medical History (Please fill in health information about your family and check if your family has been diagnosed or treated for the following)

Relation	Age	State of Health	Age of Death	Cancer	Diabetes	Hypertension	Heart Disease	Thyroid Disease	Lung Disease
Father									
Mother									
Daughter									
Son									
Siblings									

Social History

Tobacco Use: No Yes Former Type: _____ #Years: _____ # cigarettes/day: _____ How soon after waking up do you smoke: _____ Minutes Interested in quitting tobacco: No Yes Thinking about it

Passive Tobacco Exposure: No Yes

Sexually active? Yes No Any sexually transmitted diseases in the past? _____

Illicit Drug Use: No Yes Former Type: _____ Amt/day: _____ #Years: _____ Yr Quit: _____

Alcohol Use: Never Monthly Weekly Daily How many drinks are typical: _____

Caffeine Intake: Type – Coffee Tea Soda # of cups per day: _____

Exercise: 2-3x/week 3-4x/week Daily Never Occasional Rarely

Immunizations

Hepatitis B: I have received the entire Hepatitis B vaccination series

Flu Vaccine: I have received the Flu vaccine this year.

Pneumonia Vaccine: I have received a vaccine for Pneumonia.

Tdap I have received a vaccine for Tdap.