PATIENT HEALTH HISTORY FORM

PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR APPOINTMENT

Your Name: _____ Date of Birth: _____

Date of form completion: _____ Who may we thank for referring you? _____

Do you have any health concerns you would like to address at this visit? If yes, please list:

_____

_____

TELL US ABOUT YOURSELF:

Marital Status: Single_____ Married _____ Domestic Partnership _____ Divorced _____ Widowed _____

Do you have children? [ ] Yes [ ] No
If yes, please list their ages and health status:
Age/year of birth: _____ Health Status: _____
Age/year of birth: _____ Health Status: _____
Age/year of birth: _____ Health Status: _____
Age/year of birth: _____ Health Status: _____

Employment Status: full-time_____ part-time_____ retired_____ disabled_____ student_____ other_____

Occupation/type of work/jobs:_____

When was your last comprehensive health examination (blood test, EKGs, etc)? _____

PAST MEDICAL HISTORY: Do you have any of the medical problems below?

[ ] Allergies	[ ] Cancer _____	[ ] Acid Reflux	[ ] Migraine Headache
[ ] Anemia	[ ] COPD (emphysema)	[ ] Heart Attack	[ ] Osteoporosis
[ ] Angina	[ ] Chronic Pain _____	[ ] Hepatitis	[ ] Stomach Ulcer
[ ] Arthritis	[ ] Coronary Artery Disease	[ ] High Cholesterol	[ ] Stroke (CVA)
[ ] Asthma	[ ] Diverticulitis	[ ] High Blood Pressure	[ ] Seizure Disorder
[ ] Atrial Fibrillation	[ ] Enlarged Prostate	[ ] Irritable Bowel	[ ] TB/Positive PPD
[ ] Anxiety/Depression	[ ] Diabetes	[ ] Kidney Disease	[ ] Thyroid Disease
[ ] Blood Clots	[ ] Gallbladder disease	[ ] Liver Disease	[ ] Other _____

PAST SURGICAL HISTORY: Have you ever had any surgeries? Please indicate the approximate year of surgery.

[ ] Angioplasty	[ ] Carpal Tunnel Release	[ ] Hip Replacement	[ ] Fracture repair
[ ] Heart Stent	[ ] Cataract Surgery	[ ] Knee Replacement	[ ] Thyroid removed
[ ] Heart Bypass	[ ] Colon/bowel resection	[ ] LASIK	[ ] Tonsil/Adenoid removed
[ ] Pacemaker	[ ] Gallbladder removed	[ ] Liver biopsy	[ ] Back Surgery
[ ] Hernia repair	[ ] Prostate removed	[ ] Appendix removed	[ ] Breast Augmentation/plastic surgery
[ ] C-section	[ ] Hysterectomy	[ ] D&C	[ ] Breast Biopsy
[ ] Mastectomy	[ ] Fibroid removal	[ ] Other_____	

MEDICATIONS: please list any medications you are currently taking (attach a list if available).

Prescription medications	Dose	How often taken

NON-PRESCRIPTION (over-the-counter medications such as aspirin, ibuprofen, vitamins, laxatives, etc.)

Over-the-counter medications	Dose	How often taken

HERBAL PREPARATIONS

Herbal preparation	Dose	How often taken

ALLERGIES OR ADVERSE DRUG REACTIONS? Please list drug and type of reaction.

FAMILY HISTORY: Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives.

Illness/Condition	Family Member						
	Mother	Father	Maternal Grandparent	Paternal Grandparent	Siblings	Son/ Daughter	Other
Colon or rectal cancer							
Breast cancer							
Prostate cancer							
Other cancer							
Heart disease							
Diabetes							
High blood pressure							
Liver disease							
High cholesterol							
Alcohol/drug abuse							
Depression/psychiatric illness							
Genetic (inherited) disorder							
Other: _____							
Deceased?							

PREVENTIVE HEALTH CARE:

Immunizations: When was your last:

Pneumonia vaccine _____ Tetanus booster _____
Flu Shot _____ Hepatitis Vaccine _____

Health Screening: When was your last:

Colonoscopy _____
Bone Densitometry _____

Females: Do you see an Ob/Gyn provider? [ ] Yes [ ] No If yes, who? _____
When was your last menstrual period? _____
When was your last mammogram? _____
When was your last pap smear? _____

Males: When was your last prostate blood test (PSA)? _____
When was your last prostate/rectal exam? _____

Social History:

Do you currently use tobacco products?

[ ] Yes What kind (cigarettes, cigars, chewing tobacco)? _____
How often? _____
For how long? _____

[ ] No Have you ever used tobacco products?
[ ] Yes What kind (cigarettes, cigars, chewing tobacco)? _____
How often? _____
For how long? _____ Date quit? _____
[ ] No

Does anyone you live with use tobacco products? [ ] Yes [ ] No

Do you exercise outside of your job?

[ ] Yes What do you do for exercise? _____
How many days per week do you exercise? _____

[ ] No

Do you wear your seatbelt? [ ] Always [ ] Usually [ ] Sometimes [ ] Never
How often are you exposed to the sun? [ ] Often [ ] Occasionally [ ] Never
Do you wear sunscreen? [ ] Always [ ] Occasionally [ ] Never
How many cups of caffeine do you drink daily? _____

During the past month have you often been bothered by feeling down, depressed or hopeless? [ ] Yes [ ] No
During the past month have you often been bothered by little interest or pleasure in doing things? [ ] Yes [ ] No

Please circle the appropriate response:

How often do you have a drink containing alcohol?	Never	Monthly or less	2-4x per month	2-3 times per week	4 or more times per week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or Almost daily

How many times in the past year have you used an illegal drug (including marijuana) or used a prescription medication for reasons other than the drug was prescribed? _____

PLEASE BE SURE TO BRING THIS COMPLETED QUESTIONNAIRE TO YOUR APPOINTMENT