HEALTH HISTORY FORM

List any health problems, diagnosed by other physicians (check all that apply).

- Abnormal Pap Smear
- Allergies or Hay Fever
- Arthritis or Gout
- Bladder Infection
- Blood Transfusion
- Bowel or Colon Disease
- Bronchitis
- Concussion or Head Injury
- Depression or Suicidal Thoughts
- Emphysema
- Gallbladder Disease
- Gonorrhea
- Heart Attack
- Hepatitis
- High Cholesterol
- Kidney Disease
- Liver Problems
- Lymphoma
- Muscle Disease
- Pneumonia
- Ruptured Disc
- Sleep Difficulties
- Stroke or Brain Attack
- Thyroid Disease
- Varicose Veins
- HIV/AIDS
- Anemia
- Asthma
- Bleeding Problems
- Boils or Cysts
- Breast Lump
- Cancer
- Cracked Bone
- Diabetes
- Epilepsy
- Gallstones
- Headaches
- Heart Disease
- Herniated Disc
- Hodgkin's Disease
- Kidney Stones
- Lung Problems
- Meningitis
- Nephritis
- Polio
- Seizures
- Sprains or Dislocations
- Syphilis
- Tuberculosis
- Venereal Disease
- Alcohol Overdose/ Abuse
- Anxiety of Panic Attacks
- Back Problems
- Blood Clots
- Bone or Joint Disease
- Broken Bone
- Chlamydia
- Crohn's Disease
- Drug Overdose/ Abuse
- Excessive Stress
- Glaucoma
- Hearing Problems
- Heart Murmur
- High Blood Pressure
- Irritable Bowel Syndrome
- Leukemia
- Lupus
- Migraines
- Nervous Breakdown
- Rheumatic Fever
- Skin Disease
- STD
- Tendinitis
- Ulcer or Gastritis
- Vision Problems

OTHER:

FEMALES: When was your last mammogram?____________________ PAP Smear?

MALES: When was your last colonoscopy? _____________________ Prostate Exam?

IMMUNIZATION HISTORY

HAVE YOU HAD? IF SO, WHEN?

Y **N** Tetanus:__________

Y **N** Hepatitis Series:_________

Y **N** Rubella:__________

Y **N** Pneumonia:

Y **N** Influenza:

Y **N** Chickenpox or Shot:

SURGERIES:

YEAR:	REASON/PROCEDURE:	HOSPITAL/DOCTOR

OTHER HOSPITALIZATIONS:

YEAR	REASON/DIAGNOSIS	HOSPITAL/DOCTOR

HEALTH HABITS (STRICTLY CONFIDENTIAL)

CIRCLE THE ONE THAT APPLIES TO YOU

EXERCISE:

Sedentary (no exercise)   Mild Exercise   Regular Exercise

Do you drink alcohol?

YES, how much?
NO

Do you use tobacco?

YES, how many years?________ what type?__________ how much?__________ per week
NO

Former Smoker?
YES, how long ago did you quit?
NO

Do you use recreational drugs (street drugs)?

YES, how often/how much?
NO

Are you sexually active?

YES
NO

***MEDICATION LIST* (If you have a list already typed, please provide the office with a copy)**

MEDICATION:	DOSAGE/INSTRUCTIONS:

DO YOU HAVE ANY KNOWN FOOD/DRUG ALLERGIES?

YES (LIST THEM):

NO

FAMILY HISTORY

	AGE (IF ALIVE)	AT TIME OF DEATH	CAUSE OF DEATH
FATHER:			
MOTHER:			
SIBLINGS:			
CHILDREN:			

ANY OTHER MEDICAL INFORMATION THAT THE DOCTORS/NURSE PRACTIONERS NEED TO BE AWARE OF:

HOW DID YOU HEAR ABOUT US?

HAVE YOU RECENTLY VISITED ANOTHER DOCTOR OR HAD ANY LAB TEST OR RADIOLOGY TESTING? IF SO, PLEASE LIST THE INFORMATION BELOW:

THANK YOU! PLEASE RETURN FORMS TO THE FRONT DESK AND BRING YOUR PHOTO ID/ INSURANCE CARD UP WITH YOU.