HEALTH HISTORY

PATIENT NAME _____ BIRTHDATE ____/____/____ PATIENT # _____

To help us meet all your healthcare needs, please fill out **both sides** of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Today's date _____
Place of birth _____
Highest level in school _____
Occupation _____
Previous occupations _____
Marital status _____
Hobbies _____
Exercise/recreation _____
Habits:
Smoking (type & amount per day) _____
If former smoker, date quit _____
Alcohol (type & amount per week) _____
Caffeine (type & amount per day) _____
Street drugs (type & amount per day) _____
Usual weight _____
Date of last dental exam _____
Please list all allergies (foods, drugs, environment)
_____
_____
_____
Have you ever taken Fen-Phen/Redux? _____

When was your last physical exam? _____
Name of doctor _____ Phone _____
Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred: ☐ none
_____
_____
_____
_____

Please list all medicines you are currently taking (include nonprescription drugs): ☐ none
_____
_____
_____

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred): ☐ none
_____
_____
_____

Chief Complaints
Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:
_____
_____

Past Medical History
Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Migraine headaches	no	yes	Hives or Eczema	no	yes
Mumps	no	yes	Tuberculosis	no	yes	AIDS or HIV+	no	yes
Chickenpox	no	yes	Diabetes	no	yes	Infectious Mono	no	yes
Whooping Cough	no	yes	Cancer	no	yes	Bronchitis	no	yes
Scarlet Fever	no	yes	Polio	no	yes	Mitral Valve Prolapse	no	yes
Diphtheria	no	yes	Glaucoma	no	yes	Stroke	no	yes
Smallpox	no	yes	Hernia	no	yes	Hepatitis	no	yes
Pneumonia	no	yes	Blood or Plasma transfusions	no	yes	Ulcer	no	yes
Rheumatic Fever	no	yes				Kidney Disease	no	yes
Heart Disease	no	yes	Back trouble	no	yes	Thyroid Disease	no	yes
Arthritis	no	yes	High or low blood pressure	no	yes	Bleeding tendency	no	yes
Venereal Disease	no	yes				Any other disease	no	yes
Anemia	no	yes	Hemorrhoids	no	yes	(please list) _____		
Bladder Infections	no	yes	Date of last chest x-ray _____					
Epilepsy	no	yes	Asthma	no	yes			

Family History
Has any blood relative had any of the following: (Circle "no" or "yes", leave blank if uncertain)

			Relationship				Relationship
Cancer	no	yes		Stroke	no	yes	
Tuberculosis	no	yes		Epilepsy	no	yes	
Diabetes	no	yes		Allergies	no	yes	
Heart Disease	no	yes		Anemia	no	yes	
High blood pressure	no	yes		Bleeding tendency	no	yes	