

HEALTH HISTORY

DATE _____

Name:		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:		Age:	
Street Address:						
City:		State:		Zip:		
Cell Phone:		Email:				
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					
Last Physical Exam:		Medication Allergy:		Pharmacy:		

PERSONAL HEALTH HISTORY

Childhood illness:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio					
Immunizations and dates:	<input type="checkbox"/> Tetanus		<input type="checkbox"/> Chickenpox		<input type="checkbox"/> Hepatitis	
	<input type="checkbox"/> Influenza		<input type="checkbox"/> Pneumonia		<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>	

MEDICAL CONDITIONS

SURGERIES

Year	Reason	Hospital/Facility

HOSPITALIZATION

Year	Reason	Hospital

PRESCRIBED AND OTC MEDICATION

Medication	Strength	Directions

HEALTH HABITS AND PERSONAL SAFETY

Exercise	<input type="checkbox"/> Sedentary (No exercise) <input type="checkbox"/> Mild exercise (climb stairs, walk 3 blocks, golf, etc.)	
	<input type="checkbox"/> Occasional vigorous exercise (less than 4x/week for 30 min.) <input type="checkbox"/> Regular vigorous exercise (4x/week for 30 minutes)	
Diet	Are you dieting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee # cups per day _____ <input type="checkbox"/> Tea # cups per day _____ <input type="checkbox"/> Cola # per day _____	
Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	How many drinks per week? _____	
Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Quit Year: _____ <input type="checkbox"/> Cigarettes packs/day _____ # of years
	<input type="checkbox"/> Chew #/day _____ <input type="checkbox"/> Pipe #/day _____ <input type="checkbox"/> Cigars #/day _____	
Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex	Are you sexually active?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Any discomfort with intercourse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you trying for a pregnancy? (Females Only)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal Safety	Do you have frequent falls?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name: _____

Date: _____

FAMILY HEALTH HISTORY								
FATHER	ALIVE <input type="checkbox"/> DECEASED <input type="checkbox"/>	PRESENT HEALTH OR CAUSE OF DEATH	MOTHER	ALIVE <input type="checkbox"/> DECEASED <input type="checkbox"/>	PRESENT HEALTH OR CAUSE OF DEATH	SPOUSE	ALIVE <input type="checkbox"/> DECEASED <input type="checkbox"/>	PRESENT HEALTH OR CAUSE OF DEATH
Brothers	# ALIVE	PRESENT HEALTH			# DECEASED	CAUSE OF DEATH		
Sisters	# ALIVE	PRESENT HEALTH			# DECEASED	CAUSE OF DEATH		
Children	# ALIVE	PRESENT HEALTH			# DECEASED	CAUSE OF DEATH		

MENTAL HEALTH				
Is stress a major problem for you?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you feel depressed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you panic when stressed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have problems with eating or your appetite?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you cry frequently?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever attempted suicide?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you have trouble sleeping?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have you ever been to a counselor?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

WOMEN ONLY				
Age at onset of menstruation:				
Date of last menstruation:				
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Number of pregnancies _____ Number of live births _____				
Date of last pap and rectal exam? _____ Date of last mammogram? _____				
Method of Birth Control? _____				

MEN ONLY				
Do you usually get up to urinate during the night?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you feel pain or burning with urination?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any blood in your urine?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Do you feel burning discharge from penis?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any difficulty with erection or ejaculation?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any testicle pain or swelling?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Date of last prostate and rectal exam?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

OTHER PROBLEMS		
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.		
<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

I certify that the above information is correct and to the best of my knowledge.

Signature _____ Date _____