HEALTH HISTORY

TODAY'S DATE_____

Name:		☐ M ☐ F	**DOB:**		**Age:**		
Street Address:							
City		**State**		**Zip**			
Cell Phone:		**Email:**					
Marital Status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed						
Last Physical Exam:		**Medication Allergy:**		**Pharmacy:**			

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio			
Immunizations and dates:	☐ Tetanus	☐ MMR	☐ Varicella (Chickenpox)	Covid-19: ☐ Moderna ☐ Pfizer ☐ J&J
	☐ Influenza	☐ Pneumonia	☐ Shingles	Covid-19 Vaccine Dates:

MEDICAL CONDITIONS

SURGERIES/HOSPITALIZATION

Year	Reason	Hospital/Facility

PRESCRIBED AND OTC MEDICATION

Medication	Strength	Directions

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise) ☐ Occasional vigorous exercise (less than 4x/week for 30 min.) ☐ Mild exercise (climb stairs, walk 3 blocks, golf, etc.) ☐ Regular vigorous exercise (4x/week for 30 minutes)									
	Are you able to lift or transfer 50 lbs or more?	☐	Yes	☐	No	Do you have any back issues?	☐	Yes	☐	No
Diet	Are you dieting?						☐	Yes	☐	No
Caffeine	☐ None	☐ Coffee # cups per day _____		☐ Tea # cups per day _____		☐ Cola # per day _____				
Alcohol	Do you drink alcohol?						☐	Yes	☐	No
	How many drinks per week? _____									
Tobacco	Do you use tobacco?	☐ Yes ☐ No ☐ Quit Year:_____				☐ Cigarettes packs/day ____ # of years				
	☐ Chew #/day ____	☐ Pipe #/day ____				☐ Cigars #/day __				
Drugs	Do you currently use recreational or street drugs?						☐	Yes	☐	No
	Have you ever given yourself street drugs with a needle?						☐	Yes	☐	No
Sex	Are you sexually active?						☐	Yes	☐	No
	If yes, are you trying for a pregnancy? (Females Only)						☐	Yes	☐	No
	Any discomfort with intercourse?						☐	Yes	☐	No
Personal Safety	Do you have frequent falls?						☐	Yes	☐	No
	Do you have vision or hearing loss?						☐	Yes	☐	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?						☐	Yes	☐	No

Name: _____ Date: _____

FAMILY HEALTH HISTORY

FATHER	ALIVE ☐ DECEASED ☐	PRESENT HEALTH OR CAUSE OF DEATH	**MOTHER**	ALIVE ☐ DECEASED ☐	PRESENT HEALTH OR CAUSE OF DEATH	**SPOUSE**	ALIVE ☐ DECEASED ☐	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?	☐	Yes	☐	No
Do you feel depressed?	☐	Yes	☐	No
Do you panic when stressed?	☐	Yes	☐	No
Do you have problems with eating or your appetite?	☐	Yes	☐	No
Do you cry frequently?	☐	Yes	☐	No
Have you ever attempted suicide?	☐	Yes	☐	No
Have you ever seriously thought about hurting yourself?	☐	Yes	☐	No
Do you have trouble sleeping?	☐	Yes	☐	No
Have you ever been to a counselor?	☐	Yes	☐	No

FEMALE ONLY

Age at onset of menstruation: _____ Date of last menstruation: _____

Age at onset of menopause: _____

Heavy periods, irregularity, spotting, pain, or discharge? (circle)

Number of pregnancies _____ Number of live births _____

Date of last pap and rectal exam? _____ Date of last mammogram? _____

Method of Birth Control? _____

MALE ONLY

Do you feel burning or have discharge from penis?	☐	Yes	☐	No
Do you feel pain or burning with urination?	☐	Yes	☐	No
Do you usually wake up to urinate during the night?	☐	Yes	☐	No
Any blood in your urine?	☐	Yes	☐	No
Any difficulty with erection or ejaculation?	☐	Yes	☐	No
Any testicle pain or swelling?	☐	Yes	☐	No
Date of last prostate and rectal exam?	☐	Yes	☐	No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain

☐	Skin	☐	Chest/Heart	☐	Recent changes in:
☐	Head/Neck	☐	Back	☐	Weight
☐	Ears	☐	Intestinal	☐	Energy level
☐	Nose	☐	Bladder	☐	Ability to sleep
☐	Throat	☐	Bowel	☐	Other pain/discomfort:
☐	Lungs	☐	Circulation		

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

Signature_____ Date _____