Health History Form

Name (First, Middle, Last)	Date of Birth	Social Security Number	Sex
Address	City, State, & Zip		
What is the reason for your visit today?			

Please list any chronic medical problems: (Diabetes, High Blood Pressure, depression, etc)	

Please list any acute problems from the past: (Heart Attack, Stroke, Hip Fracture, etc)	

Please list any current medications: (prescription, over-the-counter, herbal)	

Please list any medication or food allergies	

Please list any surgeries or hospitalizations (Dates if Possible)	

Please list any medical problems in each of the following family members:	
Mother:	Father:
Brothers/Sisters:	Children:
Please list any other family members with heart disease:	Please list any other family members with diabetes:
Please list any family members with cancer:	Other:

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When was your last TETANUS SHOT:	When was your last FLU SHOT:
When was your last CHOLESTREOL BLOOD TEST:	

FOR WOMEN	FOR MEN
Date of your last menstrual period:	Date of your last PSA:
Last Pap Smear:	Date of your last colonoscopy: (if over 50)
Last Breast Exam:	Date of your last stool card: (if over 50)
Last Mammogram:	Date of last rectal exam: (if over 50)

Do you smoke?	YES	NO	If yes…How many packs/day?		How many years?	
Do you use other tobacco products?	YES	NO	If yes…How much/day?		How many years?	
Do you use alcohol?	YES	NO	Rarely	Occasionally	Weekly	Daily
Do you exercise?	YES	NO	Rarely	Occasionally	Weekly	Daily
Please list type of exercise:						

Are you having any of the following symptoms?
(Plese circle the appropriate response)

Fever	YES	NO	Cough	YES	NO
Chills	YES	NO	Nausea	YES	NO
Weight Loss	YES	NO	Diarrhea	YES	NO
Visual Changes	YES	NO	Burning with Urination	YES	NO
Runny Nose	YES	NO	Joint Pain	YES	NO
Chest Discomfort	YES	NO	Numbness	YES	NO
Shortness of Breath	YES	NO	Rash	YES	NO