

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	no	yes	Ulcer	no	yes
Rheumatic Fever	no	yes	transfusions			Kidney Disease	no	yes
Heart Disease	no	yes	Back trouble	no	yes	Thyroid Disease	no	yes
Arthritis	no	yes	High or low blood	no	yes	Bleeding tendency	no	yes
Venereal Disease	no	yes	pressure			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)

Cancer	no	yes	Relationship _____	Stroke	no	yes	Relationship _____
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	_____