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Health History Form

Name_____ Date of birth_____ Sexual orientation_____

Male___Female___Other____Marital status_____ Phone_____ Cell_____

Street address_____ City_____ State_____Zip_____

Email_____ Insurance_____

Do you need an interpreter for your office visits: Yes___No___Pharmacy_____

Medical History (circle below if you have had any of the following):

Allergies/Hay Fever	Artery Blockage	Fatigue	Anemia	DVT
Glaucoma	High Blood Pressure	Fibromyalgia	HIV/AIDS	Anxiety
Hearing Loss	High Cholesterol	Thyroid Problems	Arthritis	Bipolar Disorder
Rhinitis	Palpitations	Diverticulitis	Back Pain	Depression
Visual Loss	Vascular Disease	Hepatitis	Sciatic Pain	Anxiety
Breast Lump	Stroke	Hernia	Joint Pain	Asthma
Breast Cancer	Eczema	Spastic Colon	Epilepsy	COPD/Emphysema
Arrhythmia	Skin Cancer	Ulcer	Meningitis	Pneumonia
Heart Attack	Skin Problems	Reflux	Migraine	Tuberculosis
Heart Murmur	Diabetes	Abnormal Periods	Edema	Bladder/Kidney Infection

Other problems not listed_____

_____

Have you had cancer (list type and treatment)_____

_____

Have you had any of the tests below:

	Date	Reason	Where was the test done?
Heart Test			
Ultrasound			
CT Scan			
MRI			
Bone Density			
Colonoscopy			
Sigmoidoscopy			
Mammogram			

Past surgical history (include date or age you had the surgery):

Date	Surgery

List all medications, vitamins, supplements, over the counter medications (with dosage):

☐ I don't take medication

Dosage	Medication	Directions

(Please complete information on reverse)

List all allergies (medications, environmental, and food):

Medication	Environmental or food

Vaccinations (date of last):

Tetanus/Tdap_____ Flu_____ Pneumonia_____ Shingles_____

Family medical history:

	Medical problems	Living or deceased	Age at death
Father			
Mother			
Sibling			
Sibling			
Sibling			
Other			

Social history:

Present occupation_____ Past occupation_____

Places you have lived_____

Highest level of education_____

Religious preference_____ Is faith important to your health_____

Do you or have you had a drinking problem_____

Do you consume alcohol_____ Last drink_____

How many drinks a week_____

Do you use recreational drugs_____ What drugs_____

Do you smoke_____ Age started_____ Age quit_____ Packs per day_____

Do you exercise_____ How often_____ What type of exercise_____

What is your favorite food_____ Least favorite food_____

Do you have any of the following symptoms (circle all that apply below if you have any of the following):

Weight Gain	Bleeding Gums	Impotence	Memory Problems
Weight Loss	Breast Lumps	Bloody Urine	Back Pain
Night Sweats	Nipple Discharge	Frequent Urination	Joint Pain/Swelling
Fever/Chills	Chest Pain	Painful Urination	Too Thirsty
Headaches	Palpitations	Past-Sexual Abuse	Voice Change
Visual Changes	Swelling	Sexual Problems	Change in Energy
Dizzy/Vertigo	Wheezing	Genital Sores	Easy Bleeding
Earache	Short of Breath	Rash	Easy Bruising
Allergies	Poor Appetite	Skin Changes	Swollen Glands
Ringing in Ears	Abdominal Pain	Nail Changes	Anemia
Deafness	Nausea/Vomiting	Fainting	Depression
Sinus Problems	Diarrhea	Seizures	Anxiety
Bloody Nose	Constipation	Numbness	Trouble Sleeping
Cough	Bloody Stools	Paralysis	Thoughts of Suicide
Swallowing Issues	Heartburn	Tremors	Hallucinations

Women:

Number of pregnancies_____ Deliveries_____ Miscarriages_____ Abortions_____ Ectopic pregnancies_____

Age menses started_____ Age menses stopped_____ Last period_____ Last PAP smear_____

Do you have:

Painful periods_____ Pain with sex_____ Irregular periods_____ Problems getting pregnant_____

Are you sexually active_____ Using any type of birth control_____

What birth control have you used in the past_____