

HEALTH HISTORY FORM Part One

This History form provides us with information to help meet all your healthcare needs please complete both sides.
This is a confidential part of your medical record and will be kept in this office.

PATIENT NAME: _____ **DATE:** _____
DOB: _____ **Patient #:** _____
Marital Status single married widow divorce separated partner
Place of Birth: _____ **Occupation:** _____

Chief Complaint TODAY: _____

Past Medical History:

<input type="checkbox"/> <input type="checkbox"/> Y N	<input type="checkbox"/> <input type="checkbox"/> Y N	<input type="checkbox"/> <input type="checkbox"/> Y N	<input type="checkbox"/> <input type="checkbox"/> Y N
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Asthma	<input type="checkbox"/> Migraine Headaches
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Cancer	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Heart Attack/Stroke	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Bleeding tendencies	<input type="checkbox"/> Acid Reflux
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Depression	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Neuro. Disorders
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Kidney Stones/Dis.	<input type="checkbox"/> Hernia	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Sinus Infection
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Bladder Infections	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> OB/GYN Illness
<input type="checkbox"/> Smallpox	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Blood Transfusions
<input type="checkbox"/> Measles	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Mumps	<input type="checkbox"/> Anemia	<input type="checkbox"/> Polio	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Any other Diseases Please list	1 _____	
		2 _____	
		3 _____	

Past Surgeries: List by Date with Age: 1 _____
 2 _____
 3 _____

Accidents: List by Date with Age: 1 _____
 2 _____
 3 _____

Allergies: (Food, Drug, dyes, latex) _____

Social History: Alcohol: (type and amount per week) _____
 Smoking: (type and amount per day) _____
 If former smoker, date quit _____
 Caffeine: (type and amount per day) _____
 Street Drugs: (type and amount per day) _____
 Do you feel safe going home today? Do you have a living Will?
 Exercise: Hobbies:
 Psychiatric Care: Serious Illnesses:
 Do you wear Seatbelts? Any History of Family Violence?

Highest Education completed: _____
 Name of Family Doctor: _____ Date of last Physical Exam: _____

Immunizations: Tetanus/Diphtheria Influenza Other
 Hepatitis Pneumonia

Family History: HAS ANY MEMBER OF YOUR FAMILY EVER HAD THE FOLLOWING?
M: Mother S: Sister B: Brother F: Father GP: Grandparent A: Aunt

<input type="checkbox"/> <input type="checkbox"/> Y N	Relationship	<input type="checkbox"/> <input type="checkbox"/> Y N	Relationship
<input type="checkbox"/> <input type="checkbox"/>	Cancer _____	<input type="checkbox"/> <input type="checkbox"/>	Asthma _____
<input type="checkbox"/> <input type="checkbox"/>	Tuberculosis _____	<input type="checkbox"/> <input type="checkbox"/>	Chronic Lung Disease _____
<input type="checkbox"/> <input type="checkbox"/>	Diabetes _____	<input type="checkbox"/> <input type="checkbox"/>	Drug/Alcohol Abuse _____
<input type="checkbox"/> <input type="checkbox"/>	High Blood Pressure _____	<input type="checkbox"/> <input type="checkbox"/>	Depression _____
<input type="checkbox"/> <input type="checkbox"/>	Stroke _____	<input type="checkbox"/> <input type="checkbox"/>	Psychosis _____
<input type="checkbox"/> <input type="checkbox"/>	Epilepsy _____	<input type="checkbox"/> <input type="checkbox"/>	Suicide _____
<input type="checkbox"/> <input type="checkbox"/>	Allergies _____	<input type="checkbox"/> <input type="checkbox"/>	Leukemia _____
<input type="checkbox"/> <input type="checkbox"/>	Bleeding Tendencies _____	<input type="checkbox"/> <input type="checkbox"/>	Migraine Headache _____
<input type="checkbox"/> <input type="checkbox"/>	Obesity _____	<input type="checkbox"/> <input type="checkbox"/>	High Cholesterol _____
<input type="checkbox"/> <input type="checkbox"/>	Ulcer _____	<input type="checkbox"/> <input type="checkbox"/>	Kidney Disease _____
<input type="checkbox"/> <input type="checkbox"/>	Glaucoma _____	<input type="checkbox"/> <input type="checkbox"/>	Gout _____