HEALTH HISTORY

PATIENT NAME ____________________ **DOB** ______________ **AGE** ______________

Preferred Pharmacy ______________ Reason for visit ________________________________

TO HELP US MEET ALL YOUR HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETEY, THIS IS A CONFIDENTAL RECORD OF YOUR MEDICAL HISTOY AND WILL BE KEPT IN THIS OFFICE.

VITALS: **Height:_______ft.___** **Weight:_____lbs.** **(Staff use: Temp:______RR:______Pulse:______)**

1. PAST MEDICAL HISTORY - Have you ever had the following:

______ **Patient denies any PMH**

		Dates			Dates			Dates
____	Atrial Fibrillation	________	____	Coronary Artery Disease	________	____	Neuropathy	________
____	Alzheimer	________	____	Depression	________	____	Osteoarthritis	________
____	Anemia	________	____	Diabetes	________	____	Renal Failure	________
____	Anxiety	________	____	Heart Disease	________	____	Reflux/Gerd	________
____	Apnea Sleep	________	____	High Cholesterol	________	____	Seizures	________
____	Arthritis	________	____	Hypertension	________	____	Thyroid Disease	________
____	Asthma	________	____	Hypothyroidism	________	____	TIA/Stroke	________
____	Bed Wetting	________	____	Irritable Bowel	________	____	Ulcer	________
____	Cancers	________	____	Kidney Disease	________	____	Other	________
____	Chronic Kidney	________	____	Liver Disease	________	____	Other	________
____	COPD	________	____	Migraines	________	____	Other	________

PAST SURGICAL HISTORY - Have you ever had the following:

______ **Patient denies any Surgeries**

Please list all serious illnesses, operations & other hospitalizations you have experienced and indicate year these occurred

☐ Appendix	________	☐ C-Section	________	☐ Hysterectomy	________
☐ Bladder Surgery	________	☐ Eye Surgery	________	☐ Pacemaker	________
☐ Stomach Surgery	________	☐ Gallbladder	________	☐ Other Surgeries	________
☐ Joint Surgery	________	☐ Heart Surgery	________	☐ Other Surgeries	________

2. MEDICATIONS

Please list all **medicines** you are currently taking

___**Patient denies taking any Medications**

CURRENT MEDICATIONS	DOSAGE (mg)	How often per day?
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

3. Please list all **ALLERGIES** (food, drugs, and environment)

______ **Patient denies any Allergies**

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

Flowsheet

_____	Last Pap Smear	__________	_____	Last Mammo	__________	_____	Last Colonoscopy __________
_____	Last Dexa Scan	__________	_____	Last Tetanus	__________	_____	Last Flu vaccine __________
_____	Last Pneumonia Vaccine	__________	_____	Shingle Vaccine	__________	_____	Other __________

4. FAMILY HISTORY: Has any blood relative had any of the following: (**Check box, leave blank if uncertain**)

Denies family history of

	Relationship		Relationship
☐ Breast Cancer	__________	☐ High Blood Pressure	__________
☐ Colon Cancer	__________	☐ Other Problem	__________
☐ GYN Cancer	__________	☐ Other Problem	__________
☐ Diabetes	__________	☐ Other Problem	__________
☐ Heart Disease	__________	☐ Other Problem	__________

5. MENSTRUAL HISTORY:

Age of 1st period # __________

Flow: Light Medium Heavy

Last Period __________

Method of Birth Control __________

Menopause Status __________ Age Menopause # __________

6. PREGNANCY:

Total Pregnancy #	__________	Full Term #	__________	Premature #	__________
Terminated #	__________	Miscarriages #	__________	Ectopic #	__________
Multiple #	__________	Living #	__________		

7. SOCIAL HISTORY:

Tobacco: ☐ Never ☐ Minimal ☐ Yes (_____packs/day X ____yrs.) ☐ Quit_____yrs. ago (_____packs/day x _____ yrs.)

Alcohol: ☐ Never ☐ Minimal ☐ Less than 10 per week ☐ More than 10 per week

Recreational Drugs ☐ No ☐ Yes What type:____

Marital Status: ☐ Single ☐ Engaged ☐ Married ☐ Widowed ☐ Divorced ☐ Partner

Do you exercise? ☐ No ☐ Yes How often:____