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)

Condition			Condition			Condition		
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 transfusions	no	yes	Ulcer	no	yes
Rheumatic Fever	no	yes				Kidney Disease	no	yes
Heart Disease	no	yes	Back trouble	no	yes	Thyroid Disease	no	yes
Arthritis	no	yes	High or low blood pressure	no	yes	Bleeding tendency	no	yes
Venereal Disease	no	yes				Any other disease (please list) ____________	no	yes
Anemia	no	yes	Hemorrhoids	no	yes	____________		
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)

Condition			Relationship	Condition			Relationship
Cancer	no	yes	____________	Stroke	no	yes	____________
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	____________