PERSONAL HEALTH HISTORY

Name _____ Age _____ Date of birth _____

Occupation _____ Previous physician _____ Today's Date _____

CURRENT HEALTH PROBLEMS

List below all conditions for which you are currently receiving medical care.

_____

_____

_____

_____

PREVIOUS MEDICAL HISTORY

List below all previous hospitalizations, operations, and prior health problems. Include year and name of hospital if available.

_____

_____

_____

_____

HEALTH BEHAVIORS

Do you smoke? ___ Y ___ N Quantity ____ Per Day

Do you drink alcohol? ___ Y ___ N Quantity ____ Per Day

Do you use any other addicting substance? ___ Y ___ N

Per day, week, per month Specify: _____

Do you exercise? ___ Y ___ N

How often? ___ Daily ___ 3 or more per Wk ____ once wk or less

Do you have multiple sexual partners? ___ Y ___ N

VACCINATIONS

Check any vaccines you have received: Pneumonia ___

Chickenpox ___

Measles ___

Date of last tetanus booster _____

WOMEN ONLY

Date of onset of last menstrual period _____

Date of last Pap smear or pelvic examination _____

Date of last mammogram _____

Do you have a gynecologist? ___ Y ___ N

Would you like us to provide your gynecologic care? ___ Y ___ N

Number of pregnancies? _____

Number of pregnancies carried to term? _____

Number of children? _____

Have you ever had gestational diabetes? ___ Y ___ N
(diabetes during pregnancy)

Please leave blank

MEDICATIONS

List below all medications you are presently taking, including any OTC or natural products. Include strength (mg) and number of doses per day.

_____

_____

_____

_____

_____

_____

ALLERGIES

Please list all medications allergies / sensitivities including adverse reactions.

_____

_____

_____

FAMILY MEDICAL HISTORY

Does any member of your family have:	Explain below
___ Heart disease?	_____
___ Cancer?	_____
___ Asthma?	_____
___ Diabetes?	_____
___ High blood pressure?	_____
___ Depression or mental illness?	_____
___ Liver disease?	_____
___ Blood disorder?	_____
___ Tuberculosis?	_____
___ Alcoholism or substance abuse?	_____
___ Thyroid disease?	_____
___ Kidney disease?	_____
___ Osteoporosis?	_____

Please give current health status of the following family members. (If deceased, indicate age and cause of death, if known)

Father
Mother
Sisters
Brothers

Father's relatives

Mother's relatives