Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best guess. **Thank You.**

Name: ___________________________ Date of Birth: _________________ *Date* _____________

How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? ☐ Yes ☐ No

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication/Vitamin/Supplement	Dose/Strength (e.g., mg/pill)	How many times per day

ALLERGIES: Do you have allergies or reactions to:

Medications Reaction

____
____
____
____
____

Foods Reaction

____
____
____
____
____

MEDICAL HISTORY:

Major Illnesses: (i.e. high blood pressure, high cholesterol, depression, etc.)	Year of Diagnosis	Currently Treated?
1		
2		
3		
4		
5		
6		
7		
8		

SURGICAL HISTORY:

Surgeries:	Year of Surgery	Reason for Surgery
1		
2		
3		
4		
5		
6		
7		
8		

IMMUNIZATIONS: Date of most recent record.

Hepatitis A __________ Hepatitis B __________ Influenza (flu shot) ___________ MMR __________ Pneumovax (pneumonia) _________

Meningitis ___________ Tetanus (Td) _________ Varicella (chicken pox) shot or illness ___________ Tdap (tetanus & pertussis) ________

HEALTH MAINTENANCE: Date of most recent record.

Cholesterol __________________ Abnormal? □ Yes □ No

Colonscopy __________________ Abnormal? □ Yes □ No

Bone Density Scan ____________ Abnormal? □ Yes □ No

Women: Mamogram _________ Abnormal? □ Yes □ No Pap Smear ___________ Abnormal? □ Yes □ No

Men: PSA (prostate) __________ Abnormal? □ Yes □ No

FAMILY HISTORY: Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism Cancer, ____________________________

specify type Heart ____________________________

disease ____________________________

Depression/suicide ____________________________

Genetic disorders ____________________________

Diabetes ____________________________

Kidney disease ____________________________

High cholesterol ____________________________

High blood pressure ____________________________

Stroke ____________________________

Bleeding/clotting disorder ____________________________

Asthma/COPD ____________________________

Anxiety ____________________________

Other: ____________________________

SOCIAL HISTORY:

Tobacco Use

Cigarettes □ Never □ Quit Date ________________

□ Current Smoker: packs/day _____ # of yrs ______

Other Tobacco: □ Pipe □ Cigar □ Snuff □ Chew

Are you interested in quitting? □ Yes □ No

Alcohol Use

Do you drink alcohol? □ Yes □ No # drinks/week _____ Is your alcohol use a concern for you or others? □ Yes □ No

Drug Use

Do you use any recreational drugs? □ Yes □ No

Have you ever used needles to inject drugs? □ Yes □ No

Sexual Activity

Sexually active: □ Yes □ No □ Not currently

Current sex partner(s) is/are: □ male □ female

Birth control method: __________ □ None needed

Have you ever had any sexually transmitted diseases (STDs)?

□ Yes □ No

Are you interested in being screened for sexually transmitted diseases? □ Yes □ No

Caffeine Intake: □ None □ Coffee/tea/soda _____cups/day

Weight: Are you satisfied with your weight? □ Yes □ No

Diet: How do you rate your diet? □ Good □ Fair □ Poor Do you eat or drink four servings of dairy or soy daily or take calcium supplements? □ Yes □ No

Exercise: Do you exercise regularly? □ Yes □ No

What kind of exercise?_______________________________

How long (minutes)__________ How often?_____________

If you do not exercise, why?__________________________

SOCIOECONOMICS:

Occupation:____

Employer:____

Martial Status: □ Single □ Partner/Married □ Divorced

□ Widowed □ Other:_______________________________

Number of children/ages:____________________________

WOMENS HEALTH HISTORY

Preganicies: __________

Deliveries: __________

Abortions: ___________

Miscarriages: ___________

Age at start of periods: ______ Age at end of periods: _____