HEALTH HISTORY

Name: _____ Sex: M ☐ F ☐ Date _____

Date of Birth: Marital Status: Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐

Do you have any health concerns? If yes, please list:

_____

_____

_____

PAST MEDICAL HISTORY: **Check conditions that doctors have followed you for in the past**:

High blood pressure ☐	High Cholesterol ☐	Liver Disease ☐	Diabetes ☐
Thyroid Problems ☐	Kidney Disease ☐	Heart Attack and/or By-pass Surgery ☐	
Heart Failure ☐	Heart Murmur ☐	Mitral Valve Prolapse ☐	Stroke ☐
Seizures/Epilepsy ☐	Stomach Problems ☐	Intestinal Problems ☐	Reflux Disease ☐
Glaucoma ☐	Psychiatric Illness ☐	Arthritis ☐	Abnormal PAP ☐

Cancer: Type & Location _____

Other: _____

Have you ever had: Positive Tuberculosis Test Yes ☐ No ☐

Rheumatic Fever Yes ☐ No ☐

Blood Transfusion Yes ☐ No ☐

List any hospitalizations or surgeries you have had (including C-section):

_____

_____

List any drug allergies:

_____

Are you allergic to latex? Yes ☐ No ☐

List all current medications: or click for Medication Form

_____ _____ _____

_____ _____ _____

_____ _____ _____

PREVENTATIVE CARE: When was your last:

Tetanus Booster_____ Flu Shot_____ Pneumonia Vaccine_____ Hepatitis Vaccine_____

Flexible Sigmoidoscopy/Colonoscopy_____ Bone Densitometry_____

Female Only: How often do you examine your breasts? _____ Do you see an OB?GYN doctor?____

When was your last mammogram? When was your last PAP smear?

Male Only: Do you do a testicular exam? Do you have any problems with erections?_____

When was your last: prostate blood test (PSA) Prostate/rectal exam?

SOCIAL HABITS

Have you ever used tobacco products? Y☐N☐
What kind?_____
How much? _____
For how many years?_____
Date quit?_____

Do you drink alcohol? Y☐N☐How many drinks per week?__
Have you ever felt you need to cut down? Y☐N☐Have you ever felt guilty about your drinking? Y☐N☐
Do you use drugs? Y☐N☐What type?_____
How often? _____

How many glasses/cups of caffeine do you drink daily? Do you have guns in your home? Y☐N☐
Do you exercise outside of your job? Y☐N☐Do you wear seatbelts? always☐ usually☐ sometimes☐ never☐
What is your occupation? _____ Who do you live with?_____
How do you learn best? Read it☐Tell me☐Show me☐How much education have you completed? _____
Are you: sexually active Y☐N☐ If so, 1 partner☐ multiple partners☐ with women with men☐

A parent? If so, how many children?___

FAMILY HISTORY: Has anyone in your family had any of the following? (Check appropriate box with the "Comment" Pencil):

	Mother	Father	Maternal Grandparent	Paternal Grandparent	Brothers Sisters	Other
High Blood Pressures/ Hypertension						
Heart Attack/ Heart Surgery						
Diabetes						
Stroke						
Cancer (Type/Location)						
Osteoporosis						
Thyroid Problems						
Mental Illness						
Glaucoma						

Please check the **bold** category headings in which you have any problem listed below that heading:
(use the "Comment" Pencil to check the problems)

***Or if no problems check here*:** ☐

General ☐
fever_
sweats_

Respiratory ☐
cough_
shortness of breath_
wheezing_
shortness of breath with weakness_

Genitourinary ☐
urinary frequency_
burning with urination_
blood in urine_
problems urinating_
awaken at night to urinate__
problems ·with sex_
exposure to sexually transmitted disease_

Skin ☐
rash_
changing mole_
itching_
slow healing wounds_

Cardiovascular ☐
chest pain *or*_
pressure_
ankle swelling_
palpitations_

Endocrine System ☐
excessive urination_
excessive thirst_
fatigue_
heat intolerance_
cold intolerance_

Neurologic System ☐
Numbness_
tingling_
headaches_
hard to stop_

Allergy ☐
seasonal_
sneezing_
itchy eyes_
runny nose_
nasal congestion_
post nasal drip_

Hematologic System ☐
easy bruising_
easy bleeding_
blood in stool_

Eyes ☐
blurred vision_
changing vision_

GI System ☐
nausea_
vomiting_
constipation_
abdominal pain_
diarrhea_

Ear/Nose/Throat ☐
ear pain_
runny nose_
sneezing_
post nasal drip_

Mental Health ☐
depression_
anxiety_
suicidal thoughts_
insomnia_

Daily Living ☐
violence in your home_
changes in functional ability_
changes in eating habits_
changes in sleeping habits_

Musculoskeletal ☐
joint swelling_
joint pains_
muscle pains_

Nutrition ☐
On a special diet__
Weight gain__ or loss__ greater than 10 pounds