

Patient Health History Form

Name: _____ Date of birth _____ Male or Female

Please list any food or medication allergies:

Previous Surgeries: _____

Previous Hospitalizations: _____

Please list any/all medical conditions that you have been diagnosed with by a physician, and the name of the medication(s) you are taking (including over the counter medications). Please note special section below for Diabetes and Heart Attack/Stroke.

Diabetes

Insulin Dependent _____

Controlled by medicine _____

Date of last eye exam _____

Date of last foot exam _____

Date of last labs _____

History of Heart Attack or Stroke

LDL (Cholesterol Level) _____

High Blood Pressure? _____

Do you take an aspirin or blood thinner everyday?

Tobacco Use: Please indicate the type of tobacco you use (cigarettes, cigar, pipe), the number per day, and how long you have been using tobacco products. Please leave blank if you do not use tobacco products.

Type: _____ Quantity: _____ How Long: _____

Alcohol Use: Please indicate the type of alcohol you consume (beer, wine, etc.), the number of drinks per day, and how long you have been consuming alcohol on a regular basis. Please leave blank if you do not drink alcohol.

Type: _____ Quantity: _____ How Long: _____

For females please list Obstetrician or Gynecologist: _____

Last Pap Smear _____ Last Mammogram _____

Where was last mammogram done? _____

Last Menstrual Cycle _____ Are you sexually active? _____

Family History

Please complete this section for each family member indicated.

Relative	Age	Good Health	Poor Health	Deceased	If deceased indicate age and cause of death	
Father						
Mother						
Maternal Grandparents	_____ _____					
Paternal Grandparents	_____ _____					
Brothers	_____ _____ _____					
Sisters	_____ _____ _____					
Children	_____ _____ _____ _____					

Please check any of the following medical problems that run in your family. On the line, please write the family member affected by the medical condition.

Heart Disease _____	High Blood Pressure _____
Diabetes _____	Epilepsy _____
TB _____	Cancer _____
Kidney Disease _____	Arthritis _____
Allergies _____	Asthma _____
Ulcers _____	Glaucoma _____
Anemia _____	Other _____

Social History

Occupation: _____ Employer: _____

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Spouse's Name: _____ Years Married: _____

Spouse's Health: _____ Religion/Church: _____