HEALTH HISTORY

Personal Information Date:_______________

Patient Name: __________________________________ Birth Date: _____/_____/_____ Age: ____

Occupation __________________ Marital Status: ______ Name of Partner/Spouse: _______________

Race: [ ] Asian [ ] Black or African American [ ] Native American [ ] White / Caucasian

[ ] Other: ___________

Ethnicity: Do you identify with an Ethnic origin? If yes, please note: ______________________

Number of children: ______ Children's Names/Ages: _______________________________________

Names/Specialties/Locations of Other Physicians Caring for You, including previous primary care doctor:____

____

____

Medical Information

Please list any **MEDICATIONS** you are currently taking, prescribed or over the counter (use the back of the page if needed and indicate so):

Medication	Dosage	Route	Frequency

Any **Allergies** to Medication or Food (list reactions): ____

Preferred **Pharmacy**: ____

Date of Last Complete Physical Exam: ____________ Date of Last Blood Work: ___________________

Date of Last Colonoscopy: ______________ Date of Last Tetanus Shot: _________________________

For Females: Date of Last Menstrual Period: _________ Date of Last Pap Smear: _________________

History of Abnormal Pap (list date/s)? ___________ Date of Last: Mammogram: _____ DEXA: ______

Number of Pregnancies: ________ Miscarriages: ______ Terminations: _______ Living Children: _____

Method/s of Contraception: ____

If **YOU** or a **FAMILY MEMBER** has had any of the following, please circle and indicate which family member when applicable:

ADD/ADHD	Type 1 or 2 Diabetes	Respiratory Disease
Anemia	Fractures	Skin Disease
Allergies/Hay Fever	Gynecological Disease	Stomach/Colon Disease
Asthma	High Blood Pressure	Stroke
Arthritis	High Cholesterol	Seizure Disorder
Anxiety/Depression	Heart Attack	Thyroid Disorder
Alcoholism	Kidney Disease	Sexually Transmitted Disease
Blood Clots	Liver Disease	Other:
Cancer, Type/s	Neurological Disease	________________________
________________________	Osteopenia/Osteoporosis	
	________________________	

Please list any **SURGERIES** you have had and include the month/year:

____

____

____

____

Social Information

Tobacco Use: Do you smoke? _____ If so, how many cigarettes/cigars per day: _____ No. of years smoking: _____ Do you chew tobacco? _____ Have you thought about quitting? _____ Have you quit before? ____ How long?____

Alcohol Use: Do you drink alcohol? ____ If so, what type? ____________ How many in 1 week? _____

Drug Use: Any history of illegal drug use? _____ If so, what type/s? __________ When? ____________

Do you **exercise**? _____ What activities do you do, and how often in 1 week?_____________________

____

Are you on any special **diet**? _____ If so, what? ____

Do you consume any **caffeinated** products? _____ If so, what and how much per day? ______________

Have you recently noticed an increase in sadness or gloominess? _____

Have you lost interest in enjoyable activities? _____

Do you have a living will? _____ If yes, please provide us a copy.