HEALTH HISTORY

Name: _____ **DOB** _____ **Today's Date:** _____

Allergies: _____ **Current Medications** _____

PLEASE CHECK ANY OF THE FOLLOWING MEDICAL PROBLEMS YOU HAVE EXPERIENCED

Anemia	Gonorrhea	Thyroid Problems	Migraine Headaches
Bleeding Disorders	Syphilis	Goiter	Stroke
Blood Clots	Herpes	Diabetes	Epilepsy
Pneumonia	Vaginal Infections	Depression	High Blood Pressure
Bronchitis	HIV/AIDS	Suicide Attempt	Heart Disease
Asthma	Peptic Ulcer	Psychiatric Care	Heart Attack
Emphysema	Diverticulitis	Arthritis	Angina
Tuberculosis	Rectal Bleeding	Gout	Congestive Heart Failure
Hepatitis	Kidney Disease	Rheumatic Fever	Pacemaker
Liver Disease	Kidney Stones	Cataracts	High Cholesterol
Gallstone	Prostate Disease	Glaucoma	Cancer

Skin Diseases - List: _____

OTHER CONDITIONS NOT LISTED ABOVE:_____

IMMUNIZATION RECORD

- Hepatitis Vaccine
- Flu Vaccine
- Pneumococcal Vaccine
- Tetanus Toxoid Vaccine
- Other Vaccines

ARE YOUR IMMUNIZATIONS CURRENT? YES NO

SURGICAL HISTORY

- Appendectomy
- Cholecystectomy
- Hysterectomy
- Other _____

OB/GYN HISTORY

- Age at First Period
- Menopause
- Last Menstrual Period
- Last PAP Smear
- Last Breast Exam

SOCIAL HISTORY

Married Single Widowed Divorced Drug Abuse Smoker Packs per day ___ Yr Quit_____

Occupation: _____

PREVIOUS HOSPITAL ADMISSIONS

DATE	HOSPITAL	DOCTOR	WHY ADMITTED?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HAVE YOUR BLOOD RELATIVES HAD ANY OF THE FOLLOWING

	RELATIONSHIP TO YOU		RELATIONSHIP TO YOU
Cancer	_____	Stroke	_____
Diabetes	_____	Tuberculosis	_____
Heart Disease	_____	Osteoporosis	_____

FAMILY HISTORY

	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH
Father				
Mother				
Sister				
Brother				
Other				

I CERTIFY THAT THE ABOVE INFORMATION IS CORECT AND TRUE TO MY KNOWLEDGE.

_____

Patient Signature