Patient Health History

Patient Name: _____ **Date of Birth:** _____

What is the reason for visit? :_____

Allergies and Medications

List any allergies (medication, environmental, food, etc.)	**Reaction**

What pharmacy do you use? _____

List any medications you are taking (Including vitamins, herbs, diet pills, over the counter, and prescription)	**Dosage**	**Frequency**

Personal Medical History

Allergies	❑Yes ❑No	Diabetes	❑Yes ❑No	Heart Attack	❑Yes ❑No
Anemia	❑Yes ❑No	Emphysema/COPD	❑Yes ❑No	Nerve/ muscle disease	❑Yes ❑No
Anxiety	❑Yes ❑No	Acid Reflux	❑Yes ❑No	Osteoporosis	❑Yes ❑No
Arthritis/Joint Disorder	❑Yes ❑No	Heart failure	❑Yes ❑No	Seizures	❑Yes ❑No
Asthma	❑Yes ❑No	Heart murmur	❑Yes ❑No	Stroke	❑Yes ❑No
Cancer	❑Yes ❑No	HIV/AIDS	❑Yes ❑No	Substance abuse	❑Yes ❑No
If yes type: _____		High Blood Pressure	❑Yes ❑No	Thyroid disease	❑Yes ❑No
Depression	❑Yes ❑No	Kidney disease	❑Yes ❑No		

Please list any other conditions you have had here: _____

Women's Health History

When was your last pap smear? _____ Were the results normal? ❑Yes ❑No

History of abnormal pap smears? ❑Yes ❑No When was your last menstrual period? _____

Are you having regular periods? ❑Yes ❑No When was your last mammogram? _____

Have you been pregnant? ❑Yes ❑No How many times have you been pregnant? _____

How many children do you have? _____

Surgical History

Appendectomy	❑Yes ❑No	Gallbladder Surgery	❑Yes ❑No	Fracture surgery	❑Yes ❑No
C-Section	❑Yes ❑No	Colon surgery	❑Yes ❑No	Hysterectomy	❑Yes ❑No
				Spine surgery	❑Yes ❑No

Please list any other surgeries you have had here: _____

_____

(PLEASE COMPLETE REVERSE SIDE)

Family History

Relationship	Alcohol/Drug Addiction	Hypertension	Cancer	Diabetes	High Cholesterol	Heart Problems	Mental Illness	Thyroid Disease
Mother								
Father								
Sister								
Brother								
Daughter								
Son								

❑Family history unknown ❑Adopted
If cancer selected, what type of cancer? _____

Other family history: _____

Social History

Alcohol Use: ❑Yes ❑No _____#glasses of wine _____#cans of beer _____#shots of liquor

_____# of drinks containing 0.5oz of alcohol

Sexually Active? ❑Yes ❑No Partners: ❑Men ❑Women ❑Both Type of Sex: ❑Oral ❑Vaginal ❑Anal

Birth Control/Protection (if using, please describe): _____

Drug Use? ❑Yes ❑No Please check box for type of drugs used: ❑Crack ❑Cocaine ❑Ecstasy ❑IV ❑Heroin ❑LSD

❑Marijuana ❑Methamphetamine ❑Other: _____

How many times per week do you use? _____ How do you use? ❑Smoke ❑Inject ❑Other _____

Has a family member or friend ever been concerned about your drug or alcohol use? ❑Yes ❑No

Tobacco Use – Do you smoke now? ❑Yes ❑No Type of tobacco used: ❑Cigarettes ❑Cigars ❑Pipes ❑E-Cigs ❑Snuff ❑Chew

How much do you smoke? _____pack per day Years of use: _____ Year quit: _____

Are you ready to quit? ❑Yes ❑No

Do you Exercise? ❑Yes ❑No Do you follow any specific diet? ❑Yes ❑No

If yes, what kind of diet? _____

Home Environment

What type of residence do you live in? ❑Single Family ❑Multi-Family ❑Temporary ❑Homeless

Are there tobacco users/smokers in your home? ❑Yes ❑No

Is anyone a regular user of drugs at your home? ❑Yes ❑No

Are there guns/firearms in the home? ❑Yes ❑No

Is anyone being hit/hurt or touched in a bad way at home? ❑Yes ❑No

Do you have enough money for food? ❑Yes ❑No

Do you feel safe in your home? ❑Yes ❑No

Who do you live with? #_____Adults #_____Kids

Do you have money for utilities? ❑Yes ❑No

Is there anyone in the household with mental illness? ❑Yes ❑No

If yes, are they being treated for the mental illness? ❑Yes ❑No

Do you have enough money for housing? ❑Yes ❑No

Do you have transportation to get to your appointments? ❑Yes ❑No

Do you exchange sex for money, drugs, or housing? ❑Yes ❑No