Health History

Date:

rev052024

Name:	Email:*
DOB: Nickname:	Home Phone:
Age: Sex:	Cell Phone:*
Address:	Work Phone:
City: State: Zip:	Emergent Contact Person:
	Emergent Contact Phone:

Past Medical History: *Please check any of the following conditions/problems/diseases that you either now have or have been diagnosed with in the past:*

☐Abuse (physical/mental/ Sexual/Verbal/etc.	☐ Bleeding disease	☐ Gout	☐ High Blood Pressure
	☐ Cancer/Tumor	☐ Genetic diseases	☐ High Cholesterol/Triglycer.
☐ Alcoholism/Drugs	☐ Chronic Pain	☐ Headaches/Migraines	☐ Serious accident/injury
☐ Anemia	☐ Depression	☐ Heart disease	☐ Sexual diseases/VD
☐ Anxiety/Nerves	☐ Diabetes/sugar	☐ Hepatitis (Any)	☐ Sleep Apnea
☐ Asthma ☐ Allergies	☐ Epilepsy/Seizures	☐ Heartburn/GERD/Ulcers	☐ Thyroid disease

☐Others: ☐***LIST ANY CURRENT SPECIALISTS YOU SEE:***

Past Surgical History: *List the year you had any of the following:*

☐Appendectomy:	☐Tonsillectomy:
☐Colon/Rectal	☐Blood Transfusion:
☐Cataract:	☐Heart/ Cath:
☐Gallbladder:	☐Hysterectomy:
☐Hernia:	☐Tubal / Vasectomy
☐Others: ☐Major trauma/injuries	☐Bariatric (please list type) ☐Cosmetic

Current Medications: *List all medications that you take routinely or that have been prescribed for you by a doctor (include vitamins, over-the-counter medications, eye drops, herbal medications, etc.)*

Meds	Dose	How Often	Meds	Dose	How Often

Attach a medication list or ask for another sheet of paper if medications exceed the space given.

Allergies: ☐ None ☐ Antibiotics ☐ Foods ☐ Inhalants ☐ Insects ☐ Latex ☐ Meds ☐ Pollens ☐ Skin ☐ Transfusions ☐ X-ray contrast ☐ Other

Specify allergy:

Family History:

Blood Relatives	Age if Living	Age at Death	Major Illnesses &/or Cause of Death *(Choose from Past Medical History section above)*		
Mother					
Grandmother					
Grandfather					
Father					
Grandmother					
Grandfather					
Brothers #: _____					
Sisters #: _____					
Children #: _____					

List any other diseases that your blood relatives have:

Social HX:

Tobacco: ☐ Never, ☐ Now, ☐ Quit (year): _____

Type used: ☐ Cigarettes, ☐ Cigars, ☐ Pipe, ☐ Smokeless

Amount per day _____ # of years: _____

Alcohol: ☐ Never, ☐ Now, ☐ Quit (year): _____

Type used: ☐ beer, ☐ wine, ☐ liquor

Amount per week: _____ 12 oz beers; _____ 6 oz wine, _____ 2 oz shot

Drugs: ☐ Never, ☐ Now, ☐ Quit (year): _____

Type used: ☐ Pot, ☐ Cocaine, ☐ IV, ☐ Pain pills, ☐ Other: _____

Caffeine: Amount per day: _____ Coffee (cups); _____ Tea (glasses); _____ Soda (12 oz cans)

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed: Since _____

Spouse's Name:

Children's names:

Your Occupation:

Religion/Denomination:

Hobbies:

Who lives with you? ☐ Alone ☐ Spouse ☐ Children ☐ Parents ☐ Other: _____

Do you have religious or cultural practices we should be aware of? ☐ No ☐ Yes: describe:

In the past 12 months, have you experienced any of the following? (*explain any yes answers*)

Hospitalizations in past 12 months? ☐ No ☐ Yes: describe:

ER Visits in past 12 months? ☐ No ☐ Yes: describe:

Rehab in past 12 months? ☐ No ☐ Yes: describe:

Car or work accidents in past 12 months? ☐ No ☐ Yes: describe:

Have you worked with lawyers involved in health related legal disputes in the past 3 years? ☐ No ☐ Yes: describe:

Who were your last two health care providers, and date last seen, and in what city?

Why are you leaving your current health care provider?

Have you ever you been terminated by your health care provider? ☐ No ☐ Yes:

Have you participated in the health care exchange for medical insurance in the past 3 years? ☐ No ☐ Yes: describe:

How did you hear of our office or who referred you to our office?

I understand my complete truthfulness on this form is relied upon to assist in my medical care. I understand that falsification or omissions from this medical history form may be grounds for denial of acceptance or discharge from the practice.

Signature: Date: