Health History

Date:

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:			

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	

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:

Signature: Date: