

Personal Health History

Date: _____

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name: _____ First Name: _____ Middle: _____

DOB: _____ Birth Place: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Sex: M F Marital Status or Partnered: _____

Religion: _____ Referring Physician: _____

Hobbies: _____ Advanced Directives: Yes _____ No _____

FAMILY HISTORY:

RELATION	SEX	If Living		If Deceased	
		Age	Health	Age at Death	Cause
Father					
Mother					
Brother/Sister					
	M F				
	M F				
	M F				
	M F				
	M F				
Sons/Daughters					
	M F				
	M F				
	M F				
	M F				
	M F				
Maternal GM					
Maternal GF					
Paternal GM					
Paternal GF					

Do you know of any relatives who have had the following: (circle and give relation?)

Heart attack: _____	Stroke : _____	Stomach ulcer: _____
Heart disease: _____	Mental Illness: _____	Kidney problem: _____
Cancer: _____	Migraine: _____	Goiter: _____
High blood press. _____	Asthma: _____	Arthritis: _____
Leukemia: _____	Hay fever: _____	Tuberculosis: _____
Diabetes: _____	Bleeding problem _____	Osteoporosis: _____

PERSONAL HABITS: (Circle)

Yes No Do you regularly smoke? Cigarettes ___ Pipe ___ Cigars ___ For how many years: ___
 Yes No Do you usually drink over 6 cups of coffee per day?
 Yes No Do you regularly drink alcohol? 1 oz./day ___ 2 oz./day ___ 4 oz./day ___ > 6 oz./day ___
 Beer: 1 bottle/day ___ 2 bottles/day ___ over 4 bottles/day. ___ > 6 bottles/day ___
 Wine: 1 glass/day ___ 2 glasses/day ___ over 4 glasses/day ___ > 6 glasses/day ___

Preferred pharmacy _____

Street name & City _____

PLEASE TURN PAGE OVER AND COMPLETE OTHER SIDE



Yes No Have you ever used recreational drugs? Type: _____
Yes No Have you ever been in an alcohol or drug rehabilitation program?
Yes No Have you ever had a blood transfusion?
Yes No Did you serve in the military?
Yes No Do you have a regular exercise program?
Yes No Have you ever traveled abroad?

MEDICAL HISTORY:

Allergies to Medications: _____ None

Medications: (List names, dosages and how often you take them. List over the counter meds also if used regularly.)

Health conditions, illnesses or hospitalizations:

Surgeries:

Injuries or Accidents:

Immunizations: (most recent year)

Tetanus: _____ Pneumococcal: _____ Hepatitis B: _____

Women:.

Date of last Menstrual Cycle: _____

Date of last Mammogram: _____ Abnormal (Yes or No): _____

Date of last Pap Smear: _____ Abnormal (Yes or No): _____

Describe briefly your present medical symptoms:

