Date: ____________

HEALTH HISTORY

Patient name ______________________________________

Your answers on this form will help your healthcare provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: ______________________________________

Other concerns: ______________________________________

ALLERGIES	List anything that you are allergic to (medications, anesthetics, food, bee stings, etc.) and how each affects you.
Allergy	***Reaction***
1	
2	
3	
4	
5	

MEDICATIONS	Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers	
Drug	***Strength***	***Frequency***
1		
2		
3		
4		
5		
6		
7		
8		
9		

Preferred Pharmacy	**Pharmacy phone**

Immunizations Current? ☐ Yes ☐ No ☐ Don't Know

PAST MEDICAL HISTORY	SURGERIES, FRACTURES, SERIOUS ILLNESSES	
REASON	***YEAR***	***HOSPITAL***
1		
2		
3		
4		

EMERGENCY ROOM VISITS		
VISIT REASON	***DATE/YEAR***	***HOSPITAL***
1		
2		
3		
4		

PLEASE ANSWER THE FOLLOWING QUESTIONS		
Do you have active tuberculosis?	◻ Yes	◻ No
Do you have a persistent cough > 3 weeks duration?	◻ Yes	◻ No
Do you have a cough that produces blood?	◻ Yes	◻ No
Have you been exposed to anyone with tuberculosis ?	◻ Yes	◻ No
Have you traveled out of the USA this past 12 months?	◻ Yes	◻ No

PAST MEDICAL HISTORY	*Please check all that apply*	
◻ Anxiety disorder	◻ Diverticulitis	◻ Kidney Disease
◻ Arthritis	◻ Fibromyalgia	◻ Kidney Stones
◻ Asthma	◻ Gout	◻ Leg/Foot Ulcers
◻ Bleeding Disorder	◻ Has Pacemaker	◻ Liver Disease
◻ Blood Clots (or DVT)	◻ Heart Attack	◻ Osteoporosis
◻ Cancer	◻ Heart Murmur	◻ Polio
◻ Coronary Artery Disease	◻ Hiatal Hernia or Reflux Disease	◻ Pulmonary Embolism
◻ Claustrophobia	◻ HIV or AIDS	◻ Reflux or Ulcers
◻ Diabetes - Insulin	◻ High Cholesterol	◻ Stroke
◻ Diabetes - No Insulin	◻ High Blood Pressure	◻ Tuberculosis
◻ Dialysis	◻ Overactive Thyroid	◻ Other
◻ Blood Transfusion	◻ Recent Weight Changes	

FAMILY HEALTH HISTORY

RELATION	ALIVE?		AGE	SIGNIFICANT HEALTH PROBLEM
Grandmother (maternal)	Y	N		□ Addictions □ Arthritis □ Depression □ Cancer □ Diabetes □ Heart Disease □ Hypertension □ Osteoporosis □ Stroke □ Suicide
Grandfather (maternal)	Y	N		□ Addictions □ Arthritis □ Depression □ Cancer □ Diabetes □ Heart Disease □ Hypertension □ Osteoporosis □ Stroke □ Suicide
Grandmother (paternal)	Y	N		□ Addictions □ Arthritis □ Depression □ Cancer □ Diabetes □ Heart Disease □ Hypertension □ Osteoporosis □ Stroke □ Suicide
Grandfather (paternal)	Y	N		□ Addictions □ Arthritis □ Depression □ Cancer □ Diabetes □ Heart Disease □ Hypertension □ Osteoporosis □ Stroke □ Suicide
Father	Y	N		□ Addictions □ Arthritis □ Depression □ Cancer □ Diabetes □ Heart Disease □ Hypertension □ Osteoporosis □ Stroke □ Suicide
Mother	Y	N		□ Addictions □ Arthritis □ Depression □ Cancer □ Diabetes □ Heart Disease □ Hypertension □ Osteoporosis □ Stroke □ Suicide
Brother/Sister	Y	N		□ Addictions □ Arthritis □ Depression □ Cancer □ Diabetes □ Heart Disease □ Hypertension □ Osteoporosis □ Stroke □ Suicide
Brother/Sister	Y	N		□ Addictions □ Arthritis □ Depression □ Cancer □ Diabetes □ Heart Disease □ Hypertension □ Osteoporosis □ Stroke □ Suicide
Children	Y	N		□ Addictions □ Arthritis □ Depression □ Cancer □ Diabetes □ Heart Disease □ Hypertension □ Osteoporosis □ Stroke □ Suicide

PATIENT DENTAL HISTORY

	YES	NO	
Do you have regular dental check ups?			
Do your gums bleed?			
Have you ever had periodontal (gum) disease?			
Do you grind your teeth?			
Have you ever worn braces?			
Any current mouth pain?			
How many times a day do you brush your teeth?			
Do you floss?			How often?
Have you ever had any trauma to your face or mouth?			What/When?
Do you wear Dentures or Partials?			How old are they?
When was you last dental exam/cleaning?			

SEXUAL HISTORY

□ Use condom? □ Yes □ No	□ Number of sex partners in total ____
□ Sexually active?	□ Current sexual partner is □ Male □ Female □ Both
□ Have you been Screened for sexual infection?	
□ Interested in being screened for sexual infection? Check below	
□ gonorrhea □ chlamydia □ herpes □ genital warts □ HIV □ Hep B,C	

MALE ONLY	
□ Penile discharge	□ Penile lesions
□ Erection difficulty	□ Trouble urinating
□ Waking at night to urinate	

FEMALE ONLY (OBSTETRIC AND GYNECOLOGICAL HISTORY)	
□ Last PAP Smear Date ____________ Abnormal? □ Yes □ No	□ Vaginal itching, burning or discharge
□ Last Mammogram Date ____________ Abnormal? □ Yes □ No	□ Urine leak □ Hot flashes
□ Age of first mentrual period __________ □ Date of last mentrual period __________	□ Menopause If yes, age or date of last period ____________
□ Number of pregnancies: ______ births: ______ miscarriages: ______ abortions:______	□ Breast lump or nipple discharge
□ Cesarean sections? If yes, how many: ________	□ Painful intercourse
□ Bleeding between periods	□ Do you use condoms? □ Yes □ No
□ Heavy periods	□ Other birth control method used:
□ Extreme menstrual pain	□ Waking at night to urinate

SOCIAL HISTORY
Caffeine □ None □ Occasionally □ Moderate □ Heavy # of cups/cans per day _______
Alcohol Do you drink alcohol? □ Never □ Occasionally □ less than 3 time per week □ more than 3 times per week
How many drinks per week? ________ Beer ________ Wine ________ Hard Liquor ________
Have you ever felt you should Cut down on your drinking? □ Yes □ No
Have people Annoyed you by criticizing your drinking? □ Yes □ No
Have you ever felt bad or Guilty about your drinking? □ Yes □ No
Have you Ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?
□ Yes □ No
Tobacco Do you use tobacco? □ Yes □ No If yes, how old when you started smoking? ______
□ Cigarettes - ________ packs/day □ Chew - ________ /day □ Cigars - ________ /day □ # of years ________
If not currently, did you ever use tobacco? □ Yes □ No If yes, how many years ago did you quit? ________
Drugs Do you currently use recreational or street drugs? □ Yes □ No If yes, list and amounts used

NUTRITION HISTORY	
Dieting:	Protein Sources:
Salt intake: ◻ Low ◻ Medium ◻ High	Sugar intake: ◻ Low ◻ Medium ◻ High
Fruit Servings/day:	Weight Stability:
Vegetable Servings/day:	Food intolerances or dislikes:
Meals per day:	Water per day:
Other Fluids: (Coffee, tea, soda)	

Please add any other information about your health that you would like your provider to know here:

____

____

____

____

____