

HEALTH HISTORY

PATIENT NAME

BIRTHDATE

PATIENT #

To help us meet all your healthcare needs, please fill out both sides of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Today's date

Place of birth

Highest level in school

Occupation

Previous occupations

Marital status

Hobbies

Exercise/recreation

Habits:

Smoking (type & amount per day)

If former smoker, date quit

Alcohol (type & amount per week)

Caffeine (type & amount per day)

Street drugs (type & amount per day)

Usual weight

Date of last dental exam

Please list all allergies (foods; drugs, environment)

When was your last physical exam?

Name of doctor

Phone

Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred: D none

Please list all medicines you are currently taking (include nonprescription drugs): D none

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred): D none

Chief Complaints

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

AIDS or HIV+ "tl."	no	yes	Epilepsy	no	yes	Pneumonia	no	yes
Anemia ,,,	no	yes	Glaucoma	no	yes	Polio	no	yes
Arthritis :::::.....	no	yes	Heart Disease	no	yes	Rheumatic Fever	no	yes
Asthma	no	yes	H-morrhoids	no	yes	Scarlet Fever	no	yes
Back trouble	no	yes	Hepatitis	no	yes	Smallpox	no	yes
Bladder Infections.	no	yes	Hernia	no	yes	Stroke	no	yes
Bleeding tendency	no	yes	High or low blood. ...	no	yes	Thyroid Disease	no	yes
Blood or Plasma transfusions	no	yes	pressure			Tuberculosis	no	yes
Bronchitis	no	yes	Hives or Eczema	no	yes	Ulcer	no	yes
Cancer	no	yes	Infectious Mono	no	yes	Venereal Disease	no	yes
Chickenpox.	no	yes	Kidney Disease	no	yes	Whooping Cough	no	yes
Date of last chest x-ray			Measles.	no	yes	Any other disease	no	yes
Diabetes	no	yes	Migraine headaches ..	no	yes	(please list)		
Diphtheria	no	yes	Mitral Valve Prolapse .	no	yes			
			Mumps	no	yes			

Family History

Has any blood relative had any of the following: (Circle "no" or "yes", leave blank if uncertain)

Allergies	no	yes	Relationship	~	Chronic lung disease ---TIO	yes	Relationship	-
Anemia	no	yes		---	Depression	_no	yes	-
Asthma	no	yes		---	Diabetes	no		-
Bleeding tendency ----Lno	no	yes		---	Drug or alcohol problem	_no	yes	
Cancer	no	yes		---	Epilepsy	no	yes	