Your HEALTHCARE Place

Health History

NAME ____________________ DOB ____________
RACE/ETHNICITY ____________ Local Pharmacy ________ Mailorder ______

ALLERGIES ☐ None (please list allergies and what happens to you when you take it)
Drug Allergies: ____________________ Food Allergies: ____________________
____________________ ____________________
____________________ Other Allergies: ____________________

CURRENT MEDICATIONS ☐ None
____________________ ____________________
____________________ ____________________
____________________ ____________________

Vitamin or Diet Supplements: ☐ Never ☐ In Past ☐ Current (list below)
____________________ ____________________
____________________ ____________________
____________________ ____________________

PAST MEDICAL HISTORY: (please check all that apply)

☐ Allergies
☐ Arrhythmia
☐ Asthma
☐ Breast Cancer
☐ BPH (enlarged prostate)
☐ Carotid Artery Stenosis
☐ Stroke (CVA)
☐ Cholelithiasis (gallstones)
☐ Colon Cancer
☐ Congestive Heart Failure
☐ COPD
☐ Coronary Artery Disease
☐ Diabetes, Type I or II (specify type) ____________
☐ Fracture repair, ________
☐ GERD (heartburn)
☐ Headaches, migraine/tension
☐ High Cholesterol
☐ High Blood Pressure
☐ Hypothyroid
☐ Iron Deficiency Anemia
☐ Lung Cancer
☐ MI (heart attack)
☐ Obesity
☐ None/ Not applicable
☐ Osteoarthritis
☐ Osteoporosis
☐ Peptic Ulcer Disease
☐ Prostate Cancer
☐ Skin Cancer
☐ Testicular Cancer
☐ Urinary Tract Infections
☐ ____________
☐ ____________
☐ ____________
☐ ____________

PAST HOSPITALIZATIONS (please indicate date, see below for surgeries)

☐ Asthma
☐ Childbirth
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ COPD
☐ Deep Vein Thrombosis
☐ Diabetes
☐ MI (heart attack)
☐ None/ Not applicable
☐ Pneumonia
☐ Stroke
☐ Transient Ischemic Attack
☐ Other: ____________

OTHER MEDICAL PROVIDERS: (Please list all of your healthcare providers)
Primary Care Provider: ________________________________
Others (specialists): ________________________________

ADVANCED DIRECTIVES: (do you have any of the following on file?
☐ Health Care Proxy ☐ Living Will ☐ Power of Attorney ☐ DNR

SURGICAL HISTORY: (Please indicate date & details) ☐ None/ Not applicable

☐ Appendectomy	☐ Hernia Repair	☐ TURP
☐ Arthroscopy, ____________	☐ Hysterectomy	☐ Vasectomy
☐ Biopsy, ________________	☐ Joint Replacement, _______	☐ Other: _________________
☐ CABG	☐ Tubes in Ears	☐ Other: _________________
☐ Cataract Removal	☐ Prostatectomy	☐ Other: _________________
☐ Gallbladder	☐ Coronary Angioplasty	☐ Other: _________________
☐ Circumcision	☐ Sinus	☐ Other: _________________
☐ Coronary Artery Stent	☐ Tonsil/Adenoidectomy	☐ Other: _________________

FAMILY HISTORY: ☐ None/ Not applicable/Unknown
(Indicate which family member: M=mother; F=father; S=sister; B=brother; C=child; MGM= maternal grandmother; PGM=paternal grandmother; MGF=maternal grandfather; PGF= paternal grandfather)
If deceased from stated disease, please list age at death

☐ AIDS:	☐ COPD:	☐ Obesity:
☐ Alcoholism:	☐ Depression	☐ Osteoarthritis:
☐ Alzheimer’s Disease:	☐ Diabetes, Type I or II:	☐ Osteoporosis:
☐ Anxiety:	☐ Chemical Dependency:	☐ Ovarian Cancer:
☐ Asthma:	☐ Hepatitis C:	☐ Prostate Cancer:
☐ ADD/ADHD:	☐ HIV:	☐ Kidney Stones:
☐ BPH (enlarged prostate):	☐ High Cholesterol:	☐ Rheumatoid Arthritis:
☐ Breast Cancer:	☐ High Blood Pressure:	☐ Seizure Disorder:
☐ Stroke:	☐ Hypothyroid:	☐ Other: _________________
☐ Gall Stones:	☐ Lung Cancer:	☐ Other: _________________
☐ Colon Cancer	☐ Heart Attack:	☐ Other: _________________

SOCIAL HISTORY:
Occupation: ______________________________ Place of Employment: ______________________________
☐ Full Time ☐ Part Time ☐ Unemployed ☐ Homemaker ☐ Student ☐ Retired ☐ Disabled
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried Number of Children: _____
Hobbies and Activities: ____
Exercise: ____

TOBACCO/ALCOHOL/SUPPLEMENTS:
Do you use Tobacco? ☐ never smoked

	Past	Quit Date	Current	How much	How Long
Cigarettes	☐	_______	☐	_______	________
Cigars	☐	_______	☐	________	________
Smokeless	☐	_______	☐	________	________

Do you use Alcohol?		How Much?	How Often?
	☐ never used		
	☐ Beer	________	________
	☐ Wine	________	________
	☐ Liquor	________	________
Caffeine intake:	☐ None		
	☐ Coffee	________	________
	☐ Tea	________	________
	☐ Soda	________	________
	☐ Chocolate	________	________
	☐ Other _____	________	________

SUBSTANCE ABUSE HISTORY:

☐ None Other: ______________________________

MENTAL HEALTH HISTORY:

☐ None Other: ______________________________

COMMUNICABLE DISEASE HISTORY: ☐ None

☐ AIDS
☐ Botulism
☐ Brucellosis
☐ Chancroid
☐ Chicken Pox
☐ Chlamydia
☐ Condyloma (HPV)
☐ E. coli O157:H7
☐ Gonorrhea
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Herpes
☐ HIV
☐ HPV 18
☐ Invasive Hemophilis
☐ Legionellosis
☐ Lyme disease
☐ Malaria
☐ Measles (Rubeola)
☐ Mumps
☐ Pediatric HIV
☐ Pelvic Inflammatory Disease (PID)
☐ Psittacosis
☐ Rheumatic Fever
☐ Rocky Mountain Spotted Fever
☐ Rubella
☐ Salmonellosis
☐ Shigellosis
☐ Syphilis

List of Family Members:

	Age		Age
Father:	_____	Children:	_____
Mother:	_____		____
Siblings:	_____		_____
	_____		_____
	_____		

ADDITIONAL COMMENTS, QUESTIONS, OR CONCERNS:

____
____
____
____
____

Date: _______________ Patient/Guardian Signature: ______________________________

Name (print)______________________________ Relationship to patient: _______________

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