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HEALTH HISTORY FORM

Date

First Name | **Middle Name / MI** | **Last Name**

Date of Birth | **Sex** | **Home Phone**

Patient Address Line 1 | **Patient Address Line 2**

City | **State** | **Zip**

HISTORY OF PAST ILLNESS: (Have you had)

Childhood: (Check all that apply)

- [ ] Measles
- [ ] Mumps
- [ ] Chicken Pox
- [ ] Congenital Abnormalities
- [ ] Rheumatic Fever
- [ ] Heart Disease

Adult: (Check all that apply)

- [ ] Asthma
- [ ] Diabetes
- [ ] Tuberculosis
- [ ] Blood Problem
- [ ] Heart Attack
- [ ] High Blood Pressure
- [ ] Ulcer
- [ ] Gastritis

Adult: (Check all that apply)

- [ ] Kidney Problem
- [ ] Venereal Disease
- [ ] Abnormal Heart Rhythm
- [ ] Thyroid Problems
- [ ] Liver Problems
- [ ] Heart Failure
- [ ] Cancer

If you have had Cancer, please specify site:

Have you had any serious illness?

- ○ YES
- ○ NO

Have you ever had a transfusion?

- ○ YES
- ○ NO

Have you ever been hospitalized or been under medical care for very long?

- ○ YES
- ○ NO

If YES, for what reason?

MOST RECENT IMMUNIZATIONS:

Hepatitis B

- ○ YES
- ○ NO

Date

Pneumovax

- ○ YES
- ○ NO

Date

Flu Vaccine

- YES
- NO

Date _____

Tetanus

- YES
- NO

Date _____

OPERATIONS:

Have you ever had any surgery?

- YES
- NO

List: (Check all that apply)

- Appendectomy
- Ovaries Removed
- Gallbladder

List: (Check all that apply)

- Joint Replacement
- Hysterectomy
- Bypass
- Other

If you have had a Hysterectomy, what was the reason? _____

If you have had a Bypass, please explain: _____

If other, please explain: _____

ALLERGIES: _____ **REACTIONS:** _____

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ALLERGIES: _____ **REACTIONS:** _____

MEDICATIONS: _____

INJURIES:

Have you ever been seriously injured in a motor vehicle accident?

- YES
- NO

Have you had any head concussions or injuries

- YES
- NO

Have you ever been knocked unconscious?

- YES
- NO

SOCIAL HISTORY:

Marital Status _____

With whom do you live with? _____

Recreational Drug Usage?

- YES
- NO

Do you have any problems with sexual function?

- YES
- NO

Foreign travel within last year?

- YES
- NO

Coffee _____ **Tea** _____ **Cola's** _____

Alcoholic Beverages

- YES
- NO
- Never
- Other

Number of Times per week _____

Other _____

Tobacco:

- Never Smoked

Years Smoked _____

Packs per day _____

Quit smoking how many years ago:

_____

Are you employed?

- ◯ Full Time
- ◯ Part Time

Professional Title

_____

Are you exposed to fumes, dusts or solvents?

- ◯ YES
- ◯ NO

If yes, please describe:

_____

How much time have you lost from work because of your health during the past?

◯ Six Months ◯ One Year ◯ Five Years ◯ Other

If other, please explain:

_____

Education: (Years)

Grade School	College	Postgraduate
_____	_____	_____

Do you wear seat belts?

◯ ALWAYS ◯ SOMETIMES ◯ NEVER

FAMILY HISTORY:

FATHER:

Age:	Health:	If Deceased, Age at Death:	Cause of Death
_____	_____	_____	_____

MOTHER:

Age:	Health:	If Deceased, Age at Death:	Cause of Death
_____	_____	_____	_____

BROTHER / SISTER:

Age:	Health:	If Deceased, Age at Death:	Cause of Death
_____	_____	_____	_____

BROTHER / SISTER:

Age:	Health:	If Deceased, Age at Death:	Cause of Death
_____	_____	_____	_____

BROTHER / SISTER:

Age:	Health:	If Deceased, Age at Death:	Cause of Death
_____	_____	_____	_____

BROTHER / SISTER:

Age:	Health:	If Deceased, Age at Death:	Cause of Death
_____	_____	_____	_____

HUSBAND / WIFE:

Age:	Health:	If Deceased, Age at Death:	Cause of Death
_____	_____	_____	_____

SON / DAUGHTER:

Age:	Health:	If Deceased, Age at Death:	Cause of Death
_____	_____	_____	_____

SON / DAUGHTER:

Age: _____ **Health:** _____ **If Deceased, Age at Death:** _____ **Cause of Death** _____

SON / DAUGHTER:

Age: _____ **Health:** _____ **If Deceased, Age at Death:** _____ **Cause of Death** _____

SON / DAUGHTER:

Age: _____ **Health:** _____ **If Deceased, Age at Death:** _____ **Cause of Death** _____

SON / DAUGHTER:

Age: _____ **Health:** _____ **If Deceased, Age at Death:** _____ **Cause of Death** _____

Has either parent, sister, brother, child or grandparent ever had?

Stroke:

- ◯ YES
- ◯ NO

Diabetes

- ◯ YES
- ◯ NO

Tuberculosis

- ◯ YES
- ◯ NO

Heart Trouble

- ◯ YES
- ◯ NO

High Blood Pressure

- ◯ YES
- ◯ NO

Has any blood relative ever had?

Suicide

- ◯ YES
- ◯ NO

Mental illness

- ◯ YES
- ◯ NO

Bleeding Tendency

- ◯ YES
- ◯ NO

Gout or other crippling arthritis

- ◯ YES
- ◯ NO

Hereditary Defects

- ◯ YES
- ◯ NO

Cancer

- ◯ YES
- ◯ NO

If yes, type of Cancer:

_____