Patient Health History Form

Patient Name:_____________________ Date of Birth:__________________

Your answers on this form will help your clinician understand your medical concerns and conditions better. You don't have to answer any question you feel uncomfortable with. Best estimates are fine if you can't remember specific dates. Thank you.

Present Health Concerns: ____

____

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Medications

Please list your prescribed and non-prescribed medications, vitamins, home remedies

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____

Allergies to medications (please include the type of reaction)

____

____

____

Personal Medical History

Please indicate whether you have had any of the following

___ Congenital heart disease
___ Myocardial Infarction (heart attack)
___ Hypertension (high blood pressure)
___ Diabetes
___ High Cholesterol
___ Stroke
___ Thyroid problemsOther problems:

___ Coagulation (bleeding/clotting)
___ Cancer Type: __________________
___ Depression/Suicide attempt
___ Alcoholism
___ Blood transfusion Date:__________
___ Abnormal pap smear Date: _______

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____

Surgical History (please list all prior operations and dates)

Operation Date

____

____

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____

Social History

Do you smoke or chew? YES NO If yes, how much ______packs/day # of years__________

Are you a former smoker? YES NO When did you quit_____________________________

Do you drink alcohol? YES NO If yes, indicate how much _______________________

Do you use illicit/street drugs? YES NO If yes, please indicate _______________________

Have you used illicit drugs in the past? YES NO If yes, indicate ________________________

Do you exercise? YES NO If yes, indicate type/how often_________________________

Sexually active? YES NO NOT CURRENTLY

Current sex partner(s) is/are: MALE FEMALE

If sexually active, do you practice safe sex? YES NO NA

Birth control method: ______________________________

Have you ever had any sexually transmitted diseases? YES NO

Are you interested in being screened for sexually transmitted diseases? YES NO

Socioeconomics:

Occupation: ____

Education Completed: ___ Grade School ___ High School ___College ___Graduate School

Marital Status: ___Single ___Married ___Separated ___Divorced ___Widowed

___Co-habiting ___Engaged ___Other

Spouse/Partners name:____

Number of Children: ____

Who lives at home with you?____

Women's Gynecologic History:

Pregnancies ____ Deliveries ____ Abortions ____ Miscarriages _____

Most recent period _________ Age of 1st period ______________

Frequency of periods _____________ Length of each _____________

Do you have concerns about your period? ____

Do you have concerns about menopause? ____

Immunizations

Please check if you received the following vaccine with approximate dates:

Tetanus (Td/Tdap) ___Pneumonia ___ Hepatitis A/B ___

Shingles ___ Influenza (flu) ____

Family History

Please list your immediate family's health history (blood relatives)

Father____

Mother____

Siblings ____

____

Grandparents ____

____

Children ____

To the best of my knowledge, the above information is correct and complete. I understand that it is my responsibility to inform my doctor if I have a change in health status.

Patient Signature ______________________________________ Date _________________________