HEALTH HISTORY

Patient Name: ____ **Date of Birth**: _________________ **Age**: ________
(Please Print: First, Middle Initial, Last Name of patient)

Social Security Number: ________________________ Name of Emergency Contact: ______________________________

Emergency Contact Telephone Number: _____________________ Relationship to Patient: __________________________

Do you have Health Insurance? Yes ______No _______ Insurance Policy Holder Name: ___________________________

Primary Care Physician Name: ____________________________ Pharmacy Name and City/State: ____________________

Sex: Male / Female / Transgender **Status:** Single / Married / Other

Ethnicity: Hispanic or Latin _______ Not Hispanic or Latin ______ Decline to Answer ______

Race: American Indian or Alaska Native: _______ Native Hawaiian or Other Pacific Islander: _______
Asian: _______ White: _______
Black or African American: _______ Other: _______
Hispanic: ________ Decline to Answer: _______

Language Preference: English: ______ Spanish: ______ Other: ___________________________

Are you allergic to latex? Yes _______ No _______ Other Allergies: _____________________________________

MEDICATION ALLERGIES:	**REACTION TO MEDICATION:**

MEDICATION LIST: Please List any PRESCRIPTION, OVER THE COUNTER MEDICATION OR VITAMINS

MEDICATION	DOSE	HOW OFTEN	WHY ARE YOU TAKING?

(If you need additional space, please use the back of this form to add any other medications.)

Patient Name: ____ **Date of Birth**: _________________**Age:** ________

(Please Print: First, Middle Initial, Last Name)

Please check all that apply, about you personally, that you are experiencing now or have in the past six (6) months, so that we know how to best treat you. If you need additional help filling out this form, our staff will be happy to assist you.

General:	**Now**	**Past**	**Throat/Mouth:**	**Now**	**Past**	Change in appetite	**Now**	**Past**	High cholesterol/Lipids	**Now**	**Past**
Weight loss/gain			Bleeding			Change in bowel habits			High/Low Blood Pressure		
Fatigue			Dentures			Rectal Bleeding			**Neurologic:**		
Fever/Chills			Sore tongue			Constipation			Dizziness/Fainting		
Weakness			Dry Mouth			Diarrhea			Seizures		
Trouble sleeping			Sore throat			Last Colonoscopy?			Weakness		
Skin:			Hoarseness			Abdominal Pain			Numbness/Tingling		
Rashes			Thrush			**Urinary:**			Tremors		
Dryness			Non healing sores			Frequent urination			**Hematologic:**		
New Mole/Color changes			Lumps			Burning/painful urination			Bruise easily		
Hair or nail changes			Swollen Glands			Blood in urine			Clot easily		
Head:			Neck Pain			Incontinence			Hepatitis		
Headache/Migraines			Stiffness			Other			**Endocrine:**		
Head injury			**Breasts:**			**Vascular:**			Heat or cold intolerance		
Neck pain			Lumps			Calf pain w/walking			Sweating		
Ears:			Pain			Leg cramping			Frequent Urination		
Hearing loss			Discharge			Vein changes			Thirst		
Ringing in ears			Self-exams			**Musculoskeletal:**			Diabetes		
Ear pain			Date of Last Mammogram?			Muscle or joint pain			**Nose:**		
Drainage			**Respiratory:**			Osteoporosis			Discharge		
Eyes:			Asthma			Broken bones			Nosebleeds		
Vision change/loss			Coughing up blood			**Cardiovascular:**			Pressure		
Redness			Wheezing			Chest pain/ discomfort			Itching		
Blurry/double vision			Painful breathing			Tightness in chest			**List Other Symptoms:**		
Flashing lights			Other			Palpitations/ murmurs					
Date of last Eye exam?			**Gastrointestinal**			Shortness of breath w/ activity					
Itching			Difficulty Swallowing			Swelling in ankles					

SURGERIES AND HOSPITALIZATIONS: **DATE:**

(If you need additional space, please use the back of this form to add any other surgeries or hospitalizations.)

Patient Name: ____ **Date of Birth**: _________________ **Age:** ________

(Please Print: First, Middle Initial, Last Name)

SOCIAL HISTORY:

Alcohol Use:

Do you drink alcohol? Yes _____No ______ If Yes, number of drinks per week: ________

Alcohol problems in the past? Yes ______No _______

Cigarette/Tobacco Use:

Do you smoke cigarettes? Yes ______No ______Never ________

If Yes, how long have you smoked? __________

If Yes, how many packs a day do you smoke? ___________

Do you smoke/use: Pipe ______ Cigar _______Snuff _______Chewing Tobacco _________

Drug Use:

Do you use any recreational or illegal drugs? Yes _______ No ________

Have you ever used needles to inject drugs? Yes _______ No ________

Physical Activity:

Do you engage in any form of regular physical activity/exercise (at least 3 days per week)?

Yes _______ No ________

FAMILY HISTORY:

Please check all family history health conditions, both currently and in the past, to the best of your knowledge so that we know how to best treat you.

CONDITION	Mother	Father	Brother/Sister	Grandparents
Cancer				
High Blood Pressure				
Stroke				
Heart Disease				
Diabetes				

Please LIST any other medical conditions that run in your extended family. ______________________________

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X Signature: ______________________________________ **Date:** ______________________________________

Patient/Parent/Legal Guardian Signature

If Patient is a Minor (under 18):

Print Name Parent/Guardian: __________________________ Relationship to Minor: _______________________

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