HEALTH HISTORY PRACTICE:_____ DATE:_____

Name:_____ Age:_____ Birth Date:____/____/____
Last First Mi Sex ▫Male ▫Female
Highest Grade Completed_____
Place of Employment_____ How Long? ____ Occupation_____
▫Single ▫Married ▫Separated ▫Divorced ▫Widowed
Do you have someone available to assist you in time of need? ▫No ▫Yes
If married, spouse's name _____
Children's names and ages _____
Do you live alone? ▫No ▫Yes Do you drive? ▫No ▫Yes
Do you have any special spiritual or religious needs? ▫No ▫Yes
Do you have any special cultural needs? ▫No ▫Yes
Main language you speak _____
Allergies to Medications, X-ray Dyes, Food, Environmental or Other Substances ▫No ▫Yes

_____ _____ _____ _____
_____ _____ _____ _____

PAST MEDICAL HISTORY &REVIEW OF SYSTEMS

Please circle if you have had problems with or are presently complaining of any of the following:

1. High Blood Pressure	14. Pneumonia	27. Hemorrhoids	40. Blood Disorder
2. Diabetes	15 Persistent Cough	28. Gall Bladder Disease	41. Venereal Disease
3. Cancer	16.T.B.	29. Colitis	42. Anxiety
4. Heart disease	17. Hay Fever	30. Hepatitis or Jaundice	43. Depression
5. Chest pain/discomfort	18. Abdominal Discomfort	31. Thyroid Disease	44. Anemia
6. Shortness of breath	19. Indigestion	32. Head or Neck Radiation	45. Alcohol Abuse
7. Swollen Ankles	20. Nausea/Vomiting	33. Headache	46. Drug Abuse
8. Palpitations	21. Constipation	34. Kidney Disease	47. Gout
9. Light Headedness	22. Diarrhea	35. Kidney Stones	48. Difficulty eating
10. Frequent Urination	23. Blood in Stool	36. Difficulty Urinating	49. Stroke
11. Rheumatic Fever	24. Ulcers	37. Arthritis	50. Impotency
12. Asthma	25. Change in Bowel Habits	38. Low Back Problems	51.Corrective Eyewear
13 Bronchitis	26. Unexplained Wt Gain/Loss	39. Skin Disease	52. Hearing Difficulty

Any problems not listed above:_____

LEVEL OF INDEPENDENCE	SELF	NEED ASSISTANCE
Eating/Meal Preparation		
Toileting		
Walking		
Bathing/Showering		
Dressing		
Household Tasks		

Are you on a special Diet? ▫No ▫Yes Type:_____
Have you Had a change in eating habits in past year? ▫No ▫Yes
Do you use any community resources? (i.e. GECAC, Meals on Wheels, Home Health, etc.) ▫No ▫Yes

GYNECOLOGIC AND OBSTETRIC HISTORY

Age of onset periods: _____ Frequency: _____ Length of Period: _____
Pregnancies: _____ Births: _____ Miscarriages: _____
Method of Birth Control _____
Prolonged or abnormal bleeding: ▫No ▫Yes (please describe)_____
Leakage of Urine: ▫No ▫Yes (please describe)_____
Pelvic Pain: ▫No ▫Yes (please describe)_____
Abnormal Discharge: ▫No ▫Yes (please describe)_____
History of Abnormal Pap: ▫No ▫Yes (please describe)_____

THE DATES OF: PLEASE LIST AND SUPPLY

Operations: _____ _____ _____ _____

_____ _____ _____ _____

Hospitalizations other than for surgery: _____ _____ _____

_____ _____ _____ _____

Immunization history-have you had: Tetnus Immunization YES NO WHEN? _____

Hepatitis B? YES NO WHEN? _____ Flu Immunization YES NO WHEN? _____

Other? _____ When? _____ Pneumonia Immunization YES NO WHEN? _____

When was your last: Pap Smear? _____ Breast Exam? _____ Mammogram? _____

Stool check for blood? _____ Cholesterol Check? _____ Prostate Exam? _____

FAMILY HISTORY-has any member of your family (including parents, grandparents, and sibling) ever had the following?

ILLNESS	WHICH FAMILY MEMBERS?	APPROXIMATE AGE WHEN DIAGNOSED
Cancer (type)	_____	_____
Hypertension	_____	_____
Heart disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Drug or Alcohol addiction	_____	_____
Glaucoma	_____	_____
Bleeding disease	_____	_____

Other: _____

MEDICATIONS (Prescriptions, over the counter, vitamins, herbs, etc)

Drug name	Dose	Drug name	Dose
_____		_____	
_____		_____	

PREVENTION

Do you wear a seatbelt? YES NO If no why not? _____

Do you wear a bike helmet? YES NO N/A

Do you smoke? YES NO If yes how many packs/day? _____

Do you drink alcoholic beverages? YES NO If yes how much/week? _____

Do you drink coffee? YES NO If yes how many cups/day? _____

Do you drink tea? YES NO If yes how many cups/day? _____

If there is a gun in your home, is it out of reach children's reach and unloaded? YES NO N/A

Do you use drugs? (marijuana, cocaine, crack, etc) YES NO if yes explain _____

Have you ever engaged in any activity which has put you at risk of getting AIDS? YES NO

Do you wish to be tested for AIDS? YES NO

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? YES NO

If yes please explain? _____

Are you in a relationship win which you have been physically hurt (slapped, kicked, punched, bruised) by your partner? YES NO

Do you ever feel afraid of your partner? YES NO

Do you have a Living Will? YES NO

Do you have a donor card? YES NO

For Office Use Only:

Initial: _____ Date: _____ Initial: _____ Date: _____

Initial: _____ Date: _____ Initial: _____ Date: _____