



Health History

Date: _____

Patient Name: _____

Age: _____ Height: _____ Weight: _____ Sex: Female: _____ Male: _____

Marital Status: Single: _____ Married: _____ Divorced: _____ Widowed: _____

Family Physician: _____

Physician's Phone: () _____

Date of Last Physical Examination: _____

1.) Do you have or have you had: (check all that apply)

- Poor Circulation ----- Bleeding Tendency ----- Hepatitis
----- Blood Clots ----- Anemia (Low Blood) ----- Constipation
----- Stroke ----- Shortness of Breath ----- Stomach Ulcer
----- High Blood Pressure ----- Asthma ----- Kidney Disease
----- Heart Attack ----- Pneumonia ----- Epilepsy (seizures)
----- Heart Problems ----- Tuberculosis ----- Cancer
----- Rheumatic Fever ----- Diabetes (sugar) ----- Hayfever
----- Migraines ----- Herpes ----- Arthritis
----- Goiter ----- Nervous Breakdown ----- Venereal Disease
----- Aids ----- Leukemia ----- High Fever After Surgery

Yes No Do you smoke? How much? _____ How many Years? _____

Yes No Do you chew nicorette or tobacco? _____

Yes No Do you usually drink over 6 cups of coffee a day? _____

Yes No Do you regularly exercise? Type of Activity _____ How often? _____

2.) Are you PRESENTLY taking any of the following medication? (check all that apply)

- Aspirin, Bufferin, Anacin ----- Tranquillizers ----- Blood Pressure Pills
----- Weight Reducing Pills ----- Steroids ----- Blood Thinning Pills
----- Digitalis ----- Dilantin ----- Hormones
----- Phenobarbita ----- Diuretics (water pills) ----- Antibiotics
----- Laxatives ----- Pain Medication ----- Sleeping Pills
----- Birth Control Pills ----- Thyroid Medicine ----- Insulin or Diabetic Pills
----- Headache pills ----- Medicine for Arthritis ----- Iron

List ALL Medications including over the counter vitamins & herbal supplemental medications:

3.) Do you know of any blood relatives who has or had: (circle and give relationship)

Stroke	Yes	No	_____	Seizures	Yes	No	_____
Arthritis	Yes	No	_____	Asthma	Yes	No	_____
Tuberculosis	Yes	No	_____	Diabetes	Yes	No	_____
Kidney Disease	Yes	No	_____	Bleeding Tendnacy	Yes	No	_____
Leukemia	Yes	No	_____	Breast Cancer	Yes	No	_____
Goiter	Yes	No	_____	Skin Cancer	Yes	No	_____
Stomach Ulcers	Yes	No	_____	Other Cancer	Yes	No	_____
High Blood Pressure	Yes	No	_____	High Fever	Yes	No	_____
				After Surgery			

4.) Please all Operations you have had below:

	Year	Reason	Surgeon
a.)	_____	_____	_____
b.)	_____	_____	_____
c.)	_____	_____	_____

5.) Please List all allergies:

6.) Have you ever had a serious illness? (please give date and nature of illness)

7.) Have you ever had a serious injury or accident? (please give date and describe)

8.) Have you ever developed a bad scar? (Describe location and injury)

9.) Women Only

Yes	No	Are you still having menstrual periods?	Date of Last: _____
Yes	No	Are you pregnant?	No. of Pregnancies: _____
Yes	No	Have you ever had lumps in your breasts?	Births: _____
Yes	No	Do you perform self-breast exams?	C-Sections: _____
Yes	No	Have you ever had a mammogram?	
		If yes, what was date of last exam? _____	