

## PERSONAL HEALTH HISTORY

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Occupation \_\_\_\_\_ Previous physician \_\_\_\_\_ Today's date \_\_\_\_\_

### CURRENT HEALTH PROBLEMS

List below all conditions for which you are currently receiving medical care.

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### PREVIOUS MEDICAL HISTORY

List below all previous hospitalizations, operations, and prior health problems. Include year and name of hospital if available.

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### HEALTH BEHAVIORS

Do you smoke?  Yes  No Quantity \_\_\_\_\_ per day  
 Do you drink alcohol?  Yes  No Quantity \_\_\_\_\_ per day per wk per mo  
 Do you use any other addicting substance?  Yes Specify: \_\_\_\_\_  
 Do you exercise?  Yes  No How often?  Daily  3 or more times/wk  once/wk or less  
 Do you have multiple sexual partners?  Yes  No

### VACCINATIONS

Check any vaccines you have received: Pneumonia \_\_\_\_\_  
 Chickenpox \_\_\_\_\_  
 Date of last tetanus booster \_\_\_\_\_ Measles \_\_\_\_\_

### WOMEN ONLY

Date of onset of last menstrual period \_\_\_\_\_  
 Date of last Pap smear or pelvic examination \_\_\_\_\_  
 Date of last mammogram \_\_\_\_\_  
 Do you have a gynecologist?  Yes  No  
 Would you like us to provide your gynecologic care?  Yes  No  
 Number of pregnancies \_\_\_\_\_  
 Number of pregnancies carried to term \_\_\_\_\_  
 Number of children \_\_\_\_\_  
 Have you ever had gestational diabetes?  Yes  No  
 (diabetes during pregnancy)

Please leave blank

### MEDICATIONS

List below all medications you are presently taking, including any OTC or natural products. Include strength (mg) and number of doses per day.

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### ALLERGIES

Please list all medication allergies / sensitivities including adverse reactions.

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### FAMILY MEDICAL HISTORY

Does any member of your family have? Explain below

- Heart disease? \_\_\_\_\_
- Cancer? \_\_\_\_\_
- Asthma? \_\_\_\_\_
- Diabetes? \_\_\_\_\_
- High blood pressure? \_\_\_\_\_
- Depression or mental illness? \_\_\_\_\_
- Liver disease? \_\_\_\_\_
- Blood disorder? \_\_\_\_\_
- Tuberculosis? \_\_\_\_\_
- Alcoholism or substance abuse? \_\_\_\_\_
- Thyroid disease? \_\_\_\_\_
- Kidney disease? \_\_\_\_\_
- Osteoporosis? \_\_\_\_\_

Please give current health status of the following family members (if deceased, indicate age and cause of death, if known)

Father \_\_\_\_\_ Father's relatives \_\_\_\_\_  
 Mother \_\_\_\_\_  
 Sisters \_\_\_\_\_  
 Brothers \_\_\_\_\_ Mother's relatives \_\_\_\_\_