

Health History Form

Name _____ Birth date _____ Age _____

Weight _____ Height _____

Reason for visit:

Allergies (Medications, bee stings, plants, food, other)

Have you ever had any of the following: **PLEASE CIRCLE:**

ADD/ADHD	Arthritis	Asthma	Bleeding/Clotting
Bronchitis	Chemical Dependency	Convulsions	Diabetes
Ear Infections	Epilepsy	Fainting	GERD
Hay Fever	Headaches/Migraines	Hearing Disorders	STD
Heart Defect/Disease	High Cholesterol	Hypertension	Intestinal disorders
Kidney Disease	Mononucleosis	Motion Sickness	Muscle Disorder
Nervous System	Sickle Cell Anemia	Sinusitis	Skeletal Disorders
Skin Conditions	Sleep Disturbance	Stomach Upsets	Urinary Tract
Vision Disorders	Hypothyroidism	Bi Polar	Depression

Other _____

Immunization and approximate date

Tetanus _____ Flu _____ Pneumonia _____

Wears: Contacts Glasses Dentures Hearing Aids

Hospital / Surgeries: Year _____ Illness or Operation: _____

Year _____ Illness or Operation: _____

Year _____ Illness or Operation: _____

Year _____ Illness or Operation: _____

Social History

Children Yes No How Many?_____

Smoker Yes No Quit Date _____ How Much? _____ How Long?_____

Alcohol Yes No Quit Date _____ How Much? _____ How Long?_____

Caffeine Coffee Yes No How Much?_____

 Tea Yes No How Many?_____

 Pop Yes No How Many?_____

Exercise Yes No How long?_____ how often?_____

Family History

	Year Born	Deceased	Cause of Death
Mother	_____	Yes No	_____
Father	_____	Yes No	_____
Brother(s)	_____		_____
Sister(s)	_____		_____

Among your blood relatives is there any history of the following:

Hypertension	Yes	No	Relationship?_____
Heart Attack	Yes	No	Relationship?_____
Diabetes	Yes	No	Relationship?_____
Kidney Disease	Yes	No	Relationship?_____
Suicide/Depression	Yes	No	Relationship?_____
Chemical Dependency	Yes	No	Relationship?_____
Tuberculosis	Yes	No	Relationship?_____
Eating Disorders	Yes	No	Relationship?_____
Cancer	Type_____	Relationship?_____	Type_____ Relationship?_____
	Type_____	Relationship?_____	Type_____ Relationship?_____

Females only: Last Mammogram_____ Where performed_____ Last Pap _____

If you have a gynecologist that will be performing your pap, please have them send us a copy of your report.

Name of gynecologist:_____

