



Health History

Patient Name: _____ Date of Birth: _____

Who was your last primary care provider? _____

Please list other Health Care Providers or Specialists you are currently seeing as a patient:

Are there any problems you specifically want to address?

HAVE YOU EVER BEEN DIAGNOSED WITH OR TREATED FOR THE FOLLOWING

<input type="checkbox"/> Anemia	<input type="checkbox"/> Chronic Kidney Disease	<input type="checkbox"/> Esophageal/GERD	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Angina/Heart Attack	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Excessive Snoring/Sleep Apnea	
<input type="checkbox"/> Anxiety	<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Deaf/Hearing Issues	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Painful Menses
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dementia	<input type="checkbox"/> Heart Valve Problems	<input type="checkbox"/> Prostate Enlargement
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Depression	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blood Clots Location: _____		<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Vascular Disease
<input type="checkbox"/> Blind/Vision Issues	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV	<input type="checkbox"/> Migraine
<input type="checkbox"/> Cancer Type: _____		<input type="checkbox"/> Irritable Bowel Syndrome (IBS)	

Other health problems:



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Health History (continued)

MEDICATIONS

Do you have any trouble taking any of your medications? Yes No

ALLERGIES

Allergies (<i>environmental, food, drug</i>)	Reaction (<i>symptoms</i>)

FAMILY HISTORY

Father (Living: Yes No) Age: _____ Health: _____

Mother (Living: Yes No) Age: _____ Health: _____

Brother/Sister (Living: Yes No) Age: _____ Health: _____

Brother/Sister (Living: Yes No) Age: _____ Health: _____

Children How Many: **Age:** **Health:**

PREVIOUS SURGERIES (if additional surgeries attach an additional sheet of paper)

4 _____

Date of Last Colonoscopy: _____ Date of Last Bone Density: _____



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Health History *(continued)*

Women Only

First menstrual cycle (age) _____ Present form of birth control _____

Date of last menstrual cycle _____ # of pregnancies _____ Full-term _____ Live births _____

Date of last mammogram _____ Date of last pap smear _____

LIFESTYLE

Occupation: _____

Married Status: Single Married Divorced Separated Domestic Partnership Widowed

Caffeine: How much caffeine do you consume per day? (e.g. coffee, tea, chocolate, soda) _____

Alcohol

How many drinking days do you have per week? _____ On average, how many drinks per drinking day? _____

Are you or others concerned about your drinking? Yes No

Tobacco and Vape Use

Do you currently use any forms of tobacco or do you vape? (please specify what type) _____

If yes, how frequently is your usage? _____ Are you interested in quitting? Yes No

Drug Use

Do you have a history of Drug use? Yes No (if yes, what substance) _____

Exercise/Activity

What Type of Exercise do you do (example: walking, swimming, running)? _____

How long? _____ How often? _____

Falls

Have you fallen in the past year? Yes No

Do you have problems with walking or balance? Yes No

Safety

Are you in a relationship that makes you feel unsafe or have been hurt? Yes No

Do you regularly wear a seatbelt? Yes No

HIV Testing

Would you like HIV testing? Yes No (If yes, please tell the Medical Assistant). HIV testing is recommended for anyone at risk for HIV infection, including persons with a sexually transmitted disease or history of drug use, sex workers, sexual partners of HIV-infected persons, or persons at risk.

Hepatitis C Testing

Have you ever been tested for Hepatitis C? Yes No

The United States Preventative taskforce recommends screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years at least once in a lifetime.



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