



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

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

Other health concerns (please include any disabilities your provider should be aware of that is not included above):

Health History *(continued)*

MEDICATIONS

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

(If you need more room to list additional medications, please write them on a blank sheet of paper with the required information)

Medications <i>(please list all)</i>	Dose <i>(Mg., pill, etc.)</i> and Frequency <i>(once daily, twice, etc.)</i>

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)*

Type	Year
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____

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



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.