PATIENT HEALTH HISTORY

NAME____GENDER______________DOB______________

ALLERGIES____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when you take them.

_____________________________ ________________________________ ___________________________

_____________________________ ________________________________ ___________________________

_____________________________ ________________________________ ___________________________

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	COPD/EMPHYSEMA	HIGH CHOLESTEROL	RHEUMATOID ARTHRITIS
ALCOHOLISM	DEMENTIA	HIV	SEIZURE DISORDER
ALLERGIES, SEASONAL	DEPRESSION	HEPATITIS	SLEEP APNEA
ANEMIA	DIABETES 1 OR 2	IBS	STROKE
ANXIETY	DIVERTICULITIS	LUPUS	THYROID DISORDER
ARRHYTHMIA	DVT	LIVER DISEASE	ULCERATIVE COLITIS
ARTHRITIS	GERD (ACID REFLUX)	MACULAR DEGENERATION	
ASTHMA	FLAUCOMA	NEUROPATHY	
BIPLOAR	HEART DISEASE	OSTEOPENIA/OSTEOPOROSIS	
BLADDER PROBLEMS	HEART ATTACK	PARKINSON'S DISEASE	
BLEEDING PROBLEMS	HIATAL HERNIA	PERIPHERAL VASCULAR DISEASE	
CANCER:___________	HIGH BLOOD PRESSURE	PEPTIC ULCER	
HEADACHES	KIDNEY STONES	PSORIASIS	
CROHN'S DISEASE	KIDNEY DISEASE	PULMONARY EMBOLISM	

LMP:______________________

Colonoscopy________________

Mammo____________________

Bone Density_______________

Pap________________________

SURGICAL HISTORY: Please list all prior surgeries and approximate dates performed.

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____ ____

SOCIAL HISTORY:

SMOKING/TOBACCO USE: ( ) CURRENT ( ) PAST ( ) NEVER TYPE______________AMOUNT/DAY__________#OF YEARS___

ALCOHOL: ( )CURRENT ( )PAST ( )NEVER DRINKS/WEEK:__________________

ARE THERE ANY PERSONAL PROBLEMS OR CONCERNS AT HOME, WORK, OR SCHOOL YOU WOULD LIKE TO DISCUSS? _____

FAMILY HISTORY:

FATHER:

LIVING: AGE_______________ DECEASED: AGE_________________

ALCOHOLSIM	**BIPOLAR DISORDER**	**DEPRESSION**	**HIGH CHOLESTEROL**	**STROKE**
ANEMIA	**CANCER__________**	**DIABETES 1 OR2**	**HIGH BLOOD PRESSURE**	**ASTHMA**
OSTEOPOROSIS	**THYROID DISORDER**	**COPD/EMPHYSEMA**	**KIDNEY DISEASE**	**DVT**
ARTHRITIS	**DEMENTIA**	**HEART DISEASE**	**MIGRAINES**	

MOTHER:

LIVING:AGE________________ DECEASED:AGE__________________

ALCOHOLSIM	**BIPOLAR DISORDER**	**DEPRESSION**	**HIGH CHOLESTEROL**	**STROKE**
ANEMIA	**CANCER__________**	**DIABETES 1 OR2**	**HIGH BLOOD PRESSURE**	**ASTHMA**
OSTEOPOROSIS	**THYROID DISORDER**	**COPD/EMPHYSEMA**	**KIDNEY DISEASE**	**DVT**
ARTHRITIS	**DEMENTIA**	**HEART DISEASE**	**MIGRAINES**	

SIBLINGS:

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LIST OTHER MEDICAL PROVIDERS YOU SEE ON A REGULAR BASIS (CARDIOLOGIST, KIDNEY DOCTOR, DENTIST)

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PATIENT SIGNATURE:____

DATE:___________________________