

HEALTH HISTORY FORM

Patient Name: _____ **Birth Date:** _____ **Date:** _____ **Height:** _____
Weight: _____

Referring Physician: _____ **Address:** _____
Pharmacy Name: _____ **Phone number:** (____) _____

Reason for today's visit: _____
Please describe this problem: _____

PRIOR SURGERIES	CURRENT/PRIOR ILLNESSES/INJURIES

Please list all medications (prescriptions and non-prescription) that you take.
 (Include herbal remedies, vitamins, over-the-counter, street drugs, prescriptions, etc.)

MEDICATION	DOSAGE	MEDICATION	DOSAGE

Do you take any blood thinning products such as **Vitamin E, Plavix, Coumadin, Aspirin**? No Yes

Do you have any food, environmental, or drug allergies? No Yes (please explain below)

ALLERGY	TYPE	REACTION

Do you smoke? No, and never have Yes (please explain below)

TYPE OF SMOKING(cigarette, pipe, marijuana, chew, etc)	HOW MUCH	HOW LONG

Do you drink alcohol? No, and never have Socially only Daily Beer/Wine Hard Liquor

Please describe any family health issues below.

FAMILY HISTORY	Good/None	Unknown	Illnesses/Reason for Death
Mother			
Father			
Sibling(s)			
Other hereditary illness			

Patient Signature: _____ **Date:** _____
Physician Signature: _____ **Date reviewed:** _____

Patient Name: _____

Birth Date: _____

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Do you have or have you ever had any of the following:

Symptom/Illness	No	Yes, explain	Symptom/Illness	No	Yes, explain
Constitutional			Skin		
Fever or Chills			Breast Abnormalities		
Weight Loss			Nipple Discharge		
Hematologic			Last Mammogram		Date: ____ / ____ / ____
Heaptitis			Changes in moles		
HIV/Other Blood Diseases			Lesions		
Bleeding Disorders			Rashes		
Endocrine			History of Keloids		
Thyroid Problems			Neurological		
Diabetes			Neurological Problems		
Musculoskeletal			Headaches		
Arthritis			Genitourinary		
Mobility/Join Problems			Genital or Oral Herpes		
Gastrointestinal			Sexually Transmitted Disease		
Constipation			Blood in Urine		
Diarrhea			Urinary Tract Infection		
Blood in Stool			Problems Urinating		
Nausea/Vomiting			Prostate Problems		
Liver Problems			Kidney Problems		
Cardiovascular			Eyes		
Heart Problems			Vision Problems		
Deep Vein Thrombosis/DVT			ENT		
Blood Clots in Lungs/Legs			Hearing Problems		
High Blood Pressure			Sinus Problems		
Respiratory			Psychiatric		
Asthma			Mood Swings		
Sleep Apnea			Anxiety/Depression		

Please list any other conditions/illnesses not indicated above: _____

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes in my health.

Patient Signature: _____ Date: _____

Physician Signature: _____ Review Date: _____