HEALTH HISTORY

(Please complete before seeing your Health Care Professional)

Name: _____ Date: _____

Sex: M F Birth Date: _____ Age: _____

Name of Primary Care Physician: _____

MEDICAL HISTORY

List regular medications (name, dosage, and frequency):

_____ _____

_____ _____

Do you have any allergies? Yes No

Medications: Other:

_____ _____

_____ _____

List all major injuries, surgeries, procedures and/or hospitalizations: _____

_____

_____

Please check all that apply:	Personal:	Family: (Parent, Grandparent, Sibling, Child, Aunt/Uncle)	Relationship:
Anemia	_____	_____	_____
Arthritis	_____	_____	_____
Asthma/Emphysema	_____	_____	_____
Bleeding Disorder	_____	_____	_____
Cancer (type) _____	_____	_____	_____
Dementia	_____	_____	_____
Diabetes	_____	_____	_____
Stomach problems	_____	_____	_____
Glaucoma	_____	_____	_____
Heart Disease	_____	_____	_____
High Cholesterol	_____	_____	_____
High Blood Pressure	_____	_____	_____
Kidney Disease	_____	_____	_____
Liver Disease	_____	_____	_____
Migraines	_____	_____	_____
Mental Illness (specify) _____	_____	_____	_____
• Depression/Suicide			
• Anxiety/Nervous Breakdowns			
Obesity	_____	_____	_____
Stroke	_____	_____	_____
Substance abuse (alcohol, drugs)	_____	_____	_____
Thyroid Disease	_____	_____	_____
Tuberculosis	_____	_____	_____
Other (specify) _____	_____	_____	_____
Other (specify) _____	_____	_____	_____

Health Maintenance (date of last exam)

Physical Exam _____ Flex Sig/Colonoscopy _____

Cholesterol _____ Stool Hemoccult _____

Other _____ Women: Pap Smear _____

Mammogram _____

Immunizations (date(s))

Adults Children

Tetanus _____ Please provide copy of

Influenza _____ Immunization Record

Pneumovax _____

Other (Hep A, Hep B, Polio, MMR, etc.) _____

Social Habits

Tobacco? No Yes _____ packs/day for _____ years. Quit? _____

Alcohol? No Yes _____ drinks per day or week or month (circle correct time frame)

Caffeine? No Yes Coffee _____ cups/day; Pop/Tea _____ glasses/day

Recreational drugs? No Yes If yes, type and frequency: _____

Social History

Marital Status: (circle one) Single Married Divorced Widowed Separated

Occupation: _____ Living Will? No Yes

List names and ages of children living with you:

Name Age

_____

_____

_____

List names and ages of children NOT living with you:

Name Age

_____

_____

_____

Spiritual History:

Research studies show that spirituality can have a positive impact on physical and mental health. Please answer the following questions to help me understand the role of spirituality in your life.

How important is religion/spirituality to you?

a. very little b. somewhat c. quite a bit d. a great deal

Do you attend religious services? Yes No If so, how often? _____time(s) per day / wk / mo / yr

Do you have a specific religious/spiritual affiliation? _____

Do you pray? Yes No

Any aspects of your religion/spirituality I should be aware of in caring for you? _____

If you had all the money, time and confidence that you needed, what would you want to do with your life?

_____

_____