

Health History

Name: _____

Today's Date: _____

Date of Birth: _____

Problems								
Active	Past		Active	Past		Active	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Pap Smear	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Measles
<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged Prostate	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Migraines
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Erectile Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Fecal Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	Goiter	<input type="checkbox"/>	<input type="checkbox"/>	Numbness:
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Pain:
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Polio
<input type="checkbox"/>	<input type="checkbox"/>	Breast Lump	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	PMS
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis:	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	Cancer:	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Herpes:	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Constipation (chronic)	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Typhoid Fever
<input type="checkbox"/>	<input type="checkbox"/>	COPD	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroid (high)	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Incontinence
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroid (low)	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease:
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea (chronic)	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Other:								

Surgical/Hospitalization History			Pregnancy History		
Description	Year	Reason	Year	Sex	Complications

Family History							
Relation	Age	State of Health	Age at Death	Cause of Death	Relatives with the following conditions:		
					Disease		Relationship
Father					<input type="checkbox"/>	Arthritis	
Mother					<input type="checkbox"/>	Asthma	
Brothers					<input type="checkbox"/>	Cancer	
					<input type="checkbox"/>	Depression	
					<input type="checkbox"/>	Diabetes	
					<input type="checkbox"/>	Heart Disease	
Sisters					<input type="checkbox"/>	Hypertension	
					<input type="checkbox"/>	Kidney Disease	
					<input type="checkbox"/>	Other:	
					<input type="checkbox"/>		

Social History			
Current	Past	Frequency	Description & Frequency
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use	
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Use	
<input type="checkbox"/>	<input type="checkbox"/>	Drug Use	
<input type="checkbox"/>	<input type="checkbox"/>	Caffeine	
<input type="checkbox"/>	<input type="checkbox"/>	Exercise	
<input type="checkbox"/>	<input type="checkbox"/>	High Risk Sexual Behavior	
<input type="checkbox"/>	<input type="checkbox"/>	Other:	
Marital Status			
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other			
Sexual Orientation			
<input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Other:			

Allergies		<input type="checkbox"/> No known allergies
Substance	Reaction	

Medications		<input type="checkbox"/> No current medications
Name of Medication	Dose	

Preventive Care			
Procedure	Date	Immunization	Date
Colonoscopy		Influenza	
Eye Exam		Pneumococcal	
Mammogram		Tetanus	
PAP Smear			
Physical			
Prostate Exam			