**HEALTH ASSESSMENT**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:** YES NO

If yes, then please list any FOOD or MEDICATION allergies below:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medications:** Please list ALL medications and supplements you currently use alone with the dose, frequency and reason for the medication:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History:**

 High Blood Pressure Acid Reflux/Ulcers High Cholesterol

 Asthma Prostate Problems Mental Illness

 Seasonal Allergies Congestive Heart Failure Cancer

 Migraines Diabetes Stroke

 History of Heart Attack Osteoporosis

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST SURGICAL HISTORY:** Please list the names and dates of any surgeries you have had in your lifetime:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History: Please complete the following information regarding your family**

Mother: Alive Deceased Medical Diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father: Alive Deceased Medical Diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Maternal Grandmother: Alive Deceased Medical Diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Maternal Grandfather: Alive Deceased Medical Diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Paternal Grandmother: Alive Deceased Medical Diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Paternal Grandfather: Alive Deceased Medical Diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any children Yes No if yes, how many boys? \_\_\_\_ girls? \_\_\_\_\_

Do you have any siblings? Yes No if yes, how many brothers? \_\_\_ Sisters? \_\_\_\_

**Social History: Please answer honestly to the following questions**

Tobacco Use Never Rare Occasional Daily Past Use/Abuse

Alcohol Use Never Rare Occasional Daily Past Use/Abuse

Family History of Drug/Alcohol abuse Current Past

Exposure to Domestic Violence Current Past

**Legal Forms:**

Do you have a Living Will? Yes No Custodian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a Health Care Proxy? Yes No Custodian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a DNR? Yes No Custodian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you sexually active? Yes No

**Sexual Preference** Male Female Both Unknown

Have you ever had a sexually transmitted disease? Yes No

If so, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you treated? Yes No When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Maintenance:**

Date of last colonoscopy: \_\_\_\_\_\_\_ Date of last bone density scan: \_\_\_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_\_\_\_ Date of last prostate exam: \_\_\_\_\_\_\_

Date of last pneumonia shot: \_\_\_\_\_\_ Date of last physical: \_\_\_\_\_\_\_\_

Date of last mammogram: \_\_\_\_\_\_\_ Date of last GYN exam: \_\_\_\_\_\_\_