Health History

Name:_____ Today's Date: _____

Date of Birth:_____

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

Social History			
Current	Past	Frequency	Description & Frequency
❑	❑	Tobacco Use	
❑	❑	Alcohol Use	
❑	❑	Drug Use	
❑	❑	Caffeine	
❑	❑	Exercise	
❑	❑	High Risk Sexual Behavior	
❑	❑	Other:	

Marital Status					
❑ Single	❑ Married	❑ Separated	❑ Divorced	❑ Widowed	❑ Other

Sexual Orientation			
❑ Heterosexual	❑ Homosexual	❑ Bisexual	❑ Other:

Allergies	❑ No known allergies
Substance	Reaction

Medications	❑ 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			