Health History Form

Today's date _____

Name: _____ Date of Birth: _____

Thank you for taking the time to fill out this valuable information. This allows us to provide the best care possible to our patients.

Feel free to use additional people to write any information not included here that you think is important.

A. **Current/Past Medical Problems. Ex. (strokes, high blood pressure, heart trouble, high cholesterol, thyroid problems, eye problems, etc.)**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

B. **Past Surgeries. Ex. (gallbladder removed, appendectomy, hysterectomy, cataract surgery, prostate surgery, heart surgery, angioplasty, colonoscopy, etc.) Include date of surgery:**

1. _____
2. _____
3. _____
4. _____

C. **Resent Hospitalizations in the last 2 years Please provide reason, dates, and name of hospital:**

1. _____
2. _____
3. _____
4. _____

D. **Reactions to Medications taken in the past. Ex. (rash, swelling, trouble breathing, etc.)**

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

E. current Medications. Please include herbal/vitamin and over the counter medicine. Use another sheet if needed.

Name of medication	Dose taken	What date did you start	Reason for drug

F. **Family History**. Please list medical problems of close family members. Ex. (dementia, cancer) and what type, heart disease, stroke, diabetes, hypertension, depression, etc.) For anyone who has died, give the age and the cause of death if known:

Mother	Father	Siblings	Grandparents	Children
Age: _____ History:	Age: _____ History:	Brothers: ____ Sisters: ____ History:	Maternal: Paternal:	Any? _____ History:

G. **Social History**.

Marital Status:____ married ____widowed____divorced ____in a long term relationship ____single, never married

Tobacco:____Non-smoker ____Former smoker____Current Smoker

If former smoker, when did you quit smoking?_____ How much did you smoke a day?_____

If current smoker, how long have you been smoking?_____How much do you smoke a day?_____

Alcohol: Have you had a drink containing alcohol in the past year?____Yes____ No

If yes, how often?____Once a month____2-4 per month____ 2-3 per week____4 or more per week

How many drinks do you have per occasion? —1-2 —3-4—5-6—7-9—10 or more

Was drug or alcohol use ever a problem for you?____Yes____ No

H. **Sleep History**.

Do you wake up tired?____Yes____No

How much caffeine do you drink a day?____ 1-2cups____3-4cups____4or more cups____ none

Does your partner complain about your snoring?____Yes____No

Do you ever fall asleep/doze off while driving?____Yes____No

Immunizations. Please mark the appropriate box below and list dates if known.

	Date of most recent	Unable or Refused
Influenza (flu)		
Pneumococcal (pneumovax)		
Hepatitis B		
Shingles (Zostavax)		
Tetanus		

J. **For Men Only:**

Do you have any history or current problems with erectile dysfunction?____Yes____ No

Additional Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my doctors of any changes in my medical status.

Please Print _____ **Date of Birth** _____

Signature of Patient (Parent/Legal Guardian if under 18) _____ **Today's Date** _____