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 along with dose, frequency, and reason for 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 ☐ Decease 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 ☐ None ☐ Rare ☐ Occasional ☐Daily ☐ Past Use/Abuse
Alcohol Use ☐ None ☐ Rare ☐ Occasional ☐Daily ☐ Past Use/Abuse
Family History of Drug/ Alcohol Abuse ☐ Current ☐ Past
Exposure to Domestic Violence ☐ Current ☐ Past

Do you have a Living Will?	**Do you have a Health Care Proxy?**	**Do you have a DNR?**
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Custodian Name: ___________________________	Custodian Name: ___________________________	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: Documentation of any of the following would be greatly appreciated.

® DATE OF LAST COLONOSCOPY: _________
® DATE OF LAST TETANUS SHOT: _________
® DATE OF LAST CHOLESTEROL CHECK: _________
® DATE OF LAST PHYSICAL: _________
® DATE OF LAST PNEUMONIA SHOT: __________

® DATE OF LAST BONE DENSITY SCAN: _________
® DATE OF LAST PROSTATE EXAM: ________
® DATE OF LAST MAMMO: __________
® DATE OF LAST PAP/GYN EXAM: __________