Health History

Patient Name _____ Birth Date _____
Guardian (*if patient is a minor*) _____Patient Age _____
Please answer all of the questions as accurately as possible. If you do not understand the question, please ask for assistance.
Reason for visit today and/or areas of concern: _____
Primary Care Doctor(s)/Type of Practice: _____
Drug Allergies: _____ What kind of reaction? _____
_____

List previous surgeries and dates:

_____
_____

List any medications you are taking, including non-prescription drugs, vitamins and herbals:

_____
_____

Do you take any of the following regularly?

Aspirin…….	no	yes	Vitamin E……...	no	yes	Ginkgo Biloba……	no	yes
Ibuprofen/Motrin…….	no	yes						
Bilberry, Cayenne, Dong Quai, Echinacea, Feverfew, Garlic, Ginger, Ginseng, Hawthorne, Kava Kava, Licorice Root, Ma Huang, Melatonin, Red Clover, Valerian, Yohimbe	no	yes				St. John's Wort……..	no	yes
Other_____								

FAMILY HISTORY

Has any blood relative ever had the following?

Breast Cancer…….....	no	yes	High Blood Pressure……	no	yes	Kidney Disease……	no	yes
Melanoma……	no	yes	Heart Disease……...	no	yes	Depression……	no	yes
Other Cancer……...	no	yes	Stroke……...	no	yes	Diabetes……	no	yes
Problem with Anesthesia	no	yes						

PAST MEDICAL HISTORY

Have you ever had the following?

Heart Disease……..	no	yes	Cancer……..	no	yes	Stomach Ulcer……..	no	yes
Arthritis……...	no	yes	Glaucoma…….....	no	yes	Kidney Disease……	no	yes
Rheumatic Fever…….	no	yes	Asthma…….....	no	yes	Thyroid Disease……...	no	yes
Anemia……	no	yes	AIDS/HIV+……..	no	yes	Bleeding Tendency……..	no	yes
Tuberculosis……	no	yes	Stroke……...	no	yes	Mitral Valve Prolapse…..	no	yes
Diabetes……...	no	yes	Hepatitis……...	no	yes	High Blood Pressure……	no	yes
Long Term Steroid Use...	no	yes	Liver Disease……...	no	yes	Prostate Enlargement…..	no	yes
Problem with Anesthesia	no	yes						

REVIEW OF SYSTEMS

Do you have now or have you had in the past year:

Poor circulation……	no	yes	Tobacco/Nicotine Use (including gum or patch)	no	yes			
Bladder Problems…….	no	yes						
Depression……	no	yes	Alcohol Use…….	no	yes	Spinal Problems……...	no	yes
Weight Change…….	no	yes	Swollen feet/ankles……..	no	yes	Seizures……	no	yes
Dry Eyes……..	no	yes	Skin Rash…….	no	yes	Joint or Muscle Pain…….	no	yes
Chronic Cough…….	no	yes	Chronic Diarrhea…….	no	yes	Swollen Lymph Nodes….	no	yes
Chest Pain……	no	yes	Jaundice……...	no	yes	Easy Bleeding……..	no	yes
Rapid Heart Beat…….	no	yes	Chronic Constipation…...	no	yes	Easy Bruising……...	no	yes
Wounds Heal Slowly…..	no	yes	Weakness or numbness…	no	yes	Leg Pain with Rest/Walk.	no	yes

Women Only:

Are you now or are you planning to become pregnant? ……no yes

Age menses began_____	Have you had a hysterectomy?	….. no	yes
Age menses stopped_____	Do you do regular breast self exams …. no		yes
	Do you have any lumps or discharge…. no		yes
Number of pregnancies_____	Do you have fibrocystic breasts……. no		yes
Number of live births_____	Date of last mammogram_____		

Type of delivery……vaginal….c-section

I verify that the above information is true and accurate to the best of my knowledge.

_____ _____

Signature of Patient (or parent/guardian if minor) **Date**