CUCAMONGA VALLEY™ MEDICAL GROUP

Health History

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible.

PATIENT'S LAST NAME | PATIENT'S FIRST NAME | MIDDLE INITIAL | BIRTH DATE | M ☐ F ☐ GENDER

PRESENTING PROBLEM

Illness / Injury: (Please check if you have ever had)

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Ulcers
- ☐ Heart Attack
- ☐ Heart Problems (Please List)
- ☐ Heart Murmur
- ☐ Stroke
- ☐ Cancer (Please List Type)
- ☐ Hepatitis
- ☐ Kidney Stones
- ☐ Blood Transfusion
- ☐ High Cholesterol
- ☐ Arthritis
- ☐ Thyroid Problem
- ☐ Lung Problems/Asthma
- ☐ Gallstones
- ☐ Exposure To Tuberculosis
- ☐ Other (Please List)

PLEASE LIST DETAILS OF ABOVE SELECTIONS, IF ANY

Family History: (Please check if an immediate family member– parents or siblings, has ever had)

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer (Please List Type)
- ☐ Stroke
- ☐ Heart Attack
- ☐ Heart Problems (Please List)
- ☐ High Cholestero
- ☐ Other (Please List)

PLEASE LIST DETAILS OF ABOVE SELECTIONS, IF ANY

Operations/Surgeries: (Please list names and dates of all operations you have had)

☐ NONE

NAME OF OPERATION | YEAR | COMPLICATIONS

NAME OF OPERATION | YEAR | COMPLICATIONS

NAME OF OPERATION | YEAR | COMPLICATIONS

Medications: (Please list all medications and dosages, including over-the-counter and supplements)

☐ NONE

NAME OF MEDICATION | DOSAGE AND FREQUENCY | NAME OF MEDICATION | DOSAGE AND FREQUENCY

NAME OF MEDICATION | DOSAGE AND FREQUENCY | NAME OF MEDICATION | DOSAGE AND FREQUENCY

NAME OF MEDICATION | DOSAGE AND FREQUENCY | NAME OF MEDICATION | DOSAGE AND FREQUENCY

Allergies: (Please list any medication allergies and reaction)

☐ NONE

NAME OF MEDICATION | REACTION | NAME OF MEDICATION | REACTION

NAME OF MEDICATION | REACTION | NAME OF MEDICATION | REACTION

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Health History

Other Information:

Do you now use tobacco? ☐ Yes ☐ No
TYPE | AMOUNT / DAY | NO. YEARS

Have you ever used tobacco? ☐ Yes ☐ No
QUIT DATE

Do you drink alcohol? ☐ Yes ☐ No
TYPE | AMOUNT / DAY | NO. YEARS

Have you ever used alcohol? ☐ Yes ☐ No
QUIT DATE

Do you use street drugs? ☐ Yes ☐ No
TYPE | ☐ Yes ☐ No INTRAVENOUS | NO. YEARS

Have you ever used street drugs? ☐ Yes ☐ No
QUIT DATE | TYPE | ☐ Yes ☐ No INTRAVENOUS

Do you have an Advance Directive for Health Care? ☐ Yes ☐ No | Would you like more info on Advance Directives? ☐ Yes ☐ No

SIGNATURE OF PATIENT (PARENT OR GUARDIAN IF PATIENT IS A MINOR)

Date: