



# 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.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	M <input type="checkbox"/>	F <input type="checkbox"/>
PATIENT'S LAST NAME	PATIENT'S FIRST NAME	MIDDLE INITIAL	BIRTH DATE	GENDER	

PRESENTING PROBLEM

<p><b>Illness / Injury:</b> (Please check if you have ever had)</p> <table border="0"> <tr> <td><input type="checkbox"/> High Blood Pressure</td> <td><input type="checkbox"/> Stroke</td> <td><input type="checkbox"/> Arthritis</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Cancer (Please List Type)</td> <td><input type="checkbox"/> Thyroid Problem</td> </tr> <tr> <td><input type="checkbox"/> Ulcers</td> <td><input type="checkbox"/> Hepatitis</td> <td><input type="checkbox"/> Lung Problems/Asthma</td> </tr> <tr> <td><input type="checkbox"/> Heart Attack</td> <td><input type="checkbox"/> Kidney Stones</td> <td><input type="checkbox"/> Gallstones</td> </tr> <tr> <td><input type="checkbox"/> Heart Problems (Please List)</td> <td><input type="checkbox"/> Blood Transfusion</td> <td><input type="checkbox"/> Exposure To Tuberculosis</td> </tr> <tr> <td><input type="checkbox"/> Heart Murmur</td> <td><input type="checkbox"/> High Cholesterol</td> <td><input type="checkbox"/> Other (Please List)</td> </tr> </table> <p><input type="text"/></p> <p>PLEASE LIST DETAILS OF ABOVE SELECTIONS, IF ANY</p>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer (Please List Type)	<input type="checkbox"/> Thyroid Problem	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Lung Problems/Asthma	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Heart Problems (Please List)	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Exposure To Tuberculosis	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Other (Please List)	<p><b>Family History:</b> (Please check if an immediate family member- parents or siblings, has ever had)</p> <table border="0"> <tr> <td><input type="checkbox"/> High Blood Pressure</td> <td><input type="checkbox"/> Heart Attack</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Heart Problems (Please List)</td> </tr> <tr> <td><input type="checkbox"/> Cancer (Please List Type)</td> <td><input type="checkbox"/> High Cholesterol</td> </tr> <tr> <td><input type="checkbox"/> Stroke</td> <td><input type="checkbox"/> Other (Please List)</td> </tr> </table> <p><input type="text"/></p> <p>PLEASE LIST DETAILS OF ABOVE SELECTIONS, IF ANY</p>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Problems (Please List)	<input type="checkbox"/> Cancer (Please List Type)	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stroke	<input type="checkbox"/> Other (Please List)
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**Operations/Surgeries:** (Please list names and dates of all operations you have had)  NONE

<input type="text"/>	<input type="text"/>	<input type="text"/>
NAME OF OPERATION	YEAR	COMPLICATIONS
<input type="text"/>	<input type="text"/>	<input type="text"/>
NAME OF OPERATION	YEAR	COMPLICATIONS
<input type="text"/>	<input type="text"/>	<input type="text"/>
NAME OF OPERATION	YEAR	COMPLICATIONS

**Medications:** (Please list all medications and dosages, including over-the-counter and supplements)  NONE

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
NAME OF MEDICATION	DOSAGE AND FREQUENCY	NAME OF MEDICATION	DOSAGE AND FREQUENCY
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
NAME OF MEDICATION	DOSAGE AND FREQUENCY	NAME OF MEDICATION	DOSAGE AND FREQUENCY
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
NAME OF MEDICATION	DOSAGE AND FREQUENCY	NAME OF MEDICATION	DOSAGE AND FREQUENCY

**Allergies:** (Please list any medication allergies and reaction)  NONE

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
NAME OF MEDICATION	REACTION	NAME OF MEDICATION	REACTION
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
NAME OF MEDICATION	REACTION	NAME OF MEDICATION	REACTION



# Health History

## Other Information:

Do you now use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="text"/>	<input type="text"/>
		TYPE	AMOUNT / DAY	NO. YEARS
Have you ever used tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>		
		QUIT DATE		
Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="text"/>	<input type="text"/>
		TYPE	AMOUNT / DAY	NO. YEARS
Have you ever used alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>		
		QUIT DATE		
Do you use street drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>
		TYPE	INTRAVENOUS	NO. YEARS
Have you ever used street drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
		QUIT DATE	TYPE	INTRAVENOUS
Do you have an Advance Directive for Health Care?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Would you like more info on Advance Directives?		<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Date: