HEALTH HISTORY

Name_____ Date_____ Age_____
Referring Doctor_____ Date of last exam_____
Preferred Pharmacy and Phone #_____
Reason for visit_____

PERSONAL MEDICAL HISTORY

Have you been diagnosed with any of the following: give a brief explanation and approximate date

___Blood Clots_____ ___Breast Problems_____
___Diabetes_____ ___Heart Disease_____
___High Blood Pressure _____ ___Lung Problems_____
___High Cholesterol_____ ___Kidney Disease_____
___Cancer_____ ___Thyroid Problems_____
___Anemia_____ ___Asthma_____
___Hernia_____ ___Chest Pain_____
___Abdominal Pain_____ ___Recurring Diarrhea_____
___Acid Reflux_____ ___Recurring Constipation_____
___Abnormal Pap_____ ___Weight Loss_____
___Other_____

PAST SURGICAL HISTORY

List all surgeries and give approximate date

_____
_____

MEDICATIONS

Please list all medications you are currently taking including over the counter medication such as Tylenol

_____
_____

ALLERGIES

Drugs, Foods, and Environmental

_____
_____

FAMILY MEDICAL HISTORY

Has anyone in your family had the following (circle yes and indicate relationship: father, maternal , etc.)

Ovarian Cancer	Yes	Relationship_____
Uterine Cancer	Yes	Relationship_____
Breast Cancer	Yes	Relationship_____
Colon Cancer	Yes	Relationship_____
Heart Disease or Stroke	Yes	Relationship_____
Osteoporosis	Yes	Relationship_____
Kidney Disease	Yes	Relationship_____
Asthma	Yes	Relationship_____
Hypertension	Yes	Relationship_____
Other (please specify)	Yes	Relationship_____

WOMEN'S HEALTH

Date of last mammogram_____
Date of last menstrual period_____
Date of last pap smear _____
Do you have a history of abnormal paps? _____
Are you now, or could you be pregnant?_____
Current method of birth control_____
Length of cycles_____
Age of menarche_____
Total number of times you've been pregnant _____
Number of living children____ Abortions____ Miscarriages____ Ectopic (tubal)____

PAST DIAGNOSTIC TESTING

Please give approximate date
Colonoscopy _____
Bone Density_____
Ultrasound _____
Stress Test_____
CT Scan _____
X-Ray _____

SOCIAL HISTORY

Smoking History: Current _____ Former _____ Never _____
Are you exposed to second hand smoke? _____
Do you drink coffee or tea? _____
Do you drink alcohol? _____ If yes, how often? _____
Do you now or have you ever taken illegal drugs? _____
What is your occupation? _____
Are you: _____Married _____Single _____ Divorced _____ Widowed

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY DOCTOR OR ANY MEMBER OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.