

# HEALTH HISTORY

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

This is a confidential record of your medical history and will be kept in the office.

**Chief Complaints:** (Please list why you are here or your present health concerns.)

\_\_\_\_\_

\_\_\_\_\_

**Past Medical History:** (Please circle or list your medical problems.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Diabetes	No Yes	Tuberculosis	No Yes	Infectious Mono	No Yes
Hypertension	No Yes	Chicken pox	No Yes	Ankle swelling	No Yes
Sleep Apnea	No Yes	Bladder infection	No Yes	Mitral valve prolapse	No Yes
Asthma	No Yes	Gout	No Yes	Migraines	No Yes
Bronchitis	No Yes	High cholesterol	No Yes	AIDS or HIV	No Yes
Pneumonia	No Yes	Epilepsy	No Yes	Hepatitis	No Yes
Heart Disease	No Yes	Liver disease	No Yes	Kidney Disease	No Yes
Heart attack	No Yes	Thyroid disease	No Yes	Bleeding tendency	No Yes
Stroke	No Yes	Ulcer	No Yes	Rheumatic fever	No Yes
Blood clots	No Yes	Cancer	No Yes	Anemia	No Yes
Reflux	No Yes	Back pain	No Yes	Pancreatitis	No Yes

**Past Surgical History:** (Please list any surgeries you have had.)

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies:** (Please list your allergies and describe your reaction.)

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\_\_\_\_\_

**Social History:**

Do you drink alcohol? Yes No

Do you smoke? Yes No

If so, how many per day? \_\_\_\_\_

Do you use illegal drugs? Yes No

Marital status: \_\_\_\_\_

How many children? \_\_\_\_\_

Occupation \_\_\_\_\_

Place of Birth \_\_\_\_\_

**Family History:**

Are you parents still alive? Yes No (If not, please note cause of death.)

Any cancer or serious illness in the family? Please describe relative and disease.

\_\_\_\_\_



