
HEALTH HISTORY

Please complete both sides

Date	Patient's Name	Date of Birth	Age

1. List any current or past medical problems, surgeries, or hospitalizations that you have/had: *including problems for which you are currently taking any medication (use separate sheet if necessary)*

_____	_____
_____	_____
_____	_____
_____	_____

2. What particular symptoms do you want to address today?

_____	_____
_____	_____

3. List medications, dose and how often you take it: *including over the counter (OTC) medications and supplements (use separate sheet if necessary)*

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Allergies to medications: *including type of reaction*

_____	_____
_____	_____

5. Social History:

Married?	Children?	Work?	Hobbies?

6. Family History: List any medical problems in your parents/siblings: *diabetes, heart disease, stroke, cancers, etc*

7. Preventive: *Please list the date of your last*

Colonoscopy	Immunizations (<i>Tetanus, Pneumovax, Shingles, etc</i>)	Eye Exam

Women	Bone Density	Mammogram	Pap	Breast Exam
Men	PSA	Rectal Exam		

8. Have you ever smoked? No, never
 Yes, and I am currently smoking (see following questions)
 Yes, and I am *not* currently smoking (see following questions)

How many packs per day? How many years? When was the last time you quit?

9. Do you drink alcohol? No Yes

How much and how often?

(example - glass of wine with dinner 7 days week)

10. What *non* alcoholic beverages do you drink most commonly?

11. Describe your diet and exercise routine for the last three days:

Day	Breakfast	Lunch	Dinner	Snacks	Beverages	Exercise
1						
2						
3						