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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?

Over

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 *(Tetanus, Pneumovax, Shingles, etc)*	Eye Exam

Women	Bone Density	Mammogram	Pap	Breast Exam
Men	PSA	Rectal Exam		

8. Tobacco use? ☐ No, never ☐ Yes, currently using ☐ Yes, but *not* currently using

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

9. Recreational drug use?

10. Do you drink alcohol? ☐ No ☐ Yes, How much and how often?

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

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

12. Describe your sleep amount and quality:

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

Day	Breakfast	Lunch	Dinner	Snacks	Beverages	Exercise
1						
2						
3						