HEALTH HISTORY

All questions are strictly confidential and will become part of your medical record.

PERSONAL HEALTH HISTORY

Name *(Last, First, M.I.):* _____ **DOB:** _____ ☐M ☐F		Date:
Current Provider(s):	**Date of last physical exam:**	
Occupation:		

Past or Current Health Problems (circle or put √ in the box)

☐ None	☐ Celiac Disease	☐ High Blood Pressure	☐ Mental Illness
☐ Allergies	☐ Coronary Artery Disease	☐ High Cholesterol	☐ Migraines/Headaches
☐ Anemia	☐ Depression	☐ Hyperthyroidism	☐ Neuropathy
☐ Arthritis	☐ Diabetes	☐ Hypothyroidism	☐ Osteoporosis
☐ Anxiety	☐ Erectile Dysfunction	☐ Insomnia	☐ Pain*
☐ Asthma	☐ Fibromyalgia	☐ Irritable Bowel Syndrome	☐ Seizure Disorder
☐ Bleeding Problems	☐ GERD	☐ Kidney Problems	☐ Stroke
☐ Cancer	☐ Heart Disease	☐ Menopause	☐ Vertigo

*If pain is selected, please state where, severity, and how long you've had it: _____

_____

Additional space if needed:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name of the Drug	Strength	Frequency Taken

Allergies to Medications or Substances

Name	Reaction

Surgeries

Surgery	Date	Hospital / Surgeon if known

Have you ever had a blood transfusion? ☐**Yes** / ☐**No** **If yes, when?**

Have you ever been hospitalized (other than for surgery/childbirth) ☐ **Yes /** ☐ **No** **If yes, when?**

FAMILY HEALTH HISTORY			
Relative	Age at Death	**Deceased?**	**Health Problems**
Father		☐ Y / N ☐	
Mother		☐ Y / N ☐	
Paternal Grandfather		☐ Y / N ☐	
Paternal Grandmother		☐ Y / N ☐	
Maternal Grandfather		☐ Y / N ☐	
Maternal Grandmother		☐ Y / N ☐	
Please indicate if you have any siblings or children, how many of each, and if they have any health issues.			
Brother(s)			
Sister(s)			
Sons(s)			
Daughter(s)			
Additional space if needed:			

HEALTH HABITS AND PERSONAL SAFETY						
Exercise	☐ Y / N ☐					
Caffeine	☐ Y / N ☐	☐ Coffee	☐ Pop	☐ Tea	☐ Cocoa	☐ Energy Drinks	# per day
Alcohol	☐ Y / N ☐	☐ Beer	☐ Spirits	☐ Liqueur	# per day	# per week	# per month	Do you binge? ☐ Y / N ☐
Tobacco	☐ Y / N ☐	☐ Cigarettes	☐ Cigars	☐ Pipe	☐ E-cigarettes/Vape	☐ Smokeless	# per day
Drugs	☐ Y / N ☐					

GENDER SPECIFIC QUESTIONS:			
FEMALE		**MALE**	
Age at time of first period		Need to urinate at night	☐ Y / N ☐
Date of last period		Burning with urination	☐ Y / N ☐
Number of pregnancies		Blood in urine	☐ Y / N ☐
Number of live births		Burning discharge from penis	☐ Y / N ☐
PMS symptoms	☐ Y / N ☐	Decrease in urine stream	☐ Y / N ☐
Breast problems	☐ Y / N ☐	Erectile dysfunction	☐ Y / N ☐
Date of last pap		Testicular pain or swelling	☐ Y / N ☐
Date of last mammogram		Date of last prostate exam	
Date of last colonoscopy		Date of last colonoscopy	
Date of last bone density exam			

Any other concerns or questions: