Health History

Name: _____ **Date of Birth:**___/___/_____ **Date:**___/___/_____

Allergies: Please circle Yes or No if you have had a reaction to any of the following or list allergy to medication:

Medication		What Type Of Reaction	Medication	What Type Of Reaction
Latex	YES/NO			
Penicillin	YES/NO			
Sulfa	YES/NO			

Medications:

Medication	Strength	How Often	Medication	Strength	How Often

Drug Use: Never:_____ Past(enter when last used):_____
Intravenous Drug Use (even if used only once): _____
Smoking Status: Current Smoker___ PPD____ Years____ Quit/Year_____ Never____
Alcohol: Yes/No/Socially Amount _____per day/week/ month
When was your last yearly exam? _____ Normal or Abnormal

Have you been or currently are being treated for any of the following:

		IF YES, PLEASE EXPLAIN			IF YES, PLEASE EXPLAIN
Asthma	YES/NO		COPD	YES/NO	
Diabetes	YES/NO		Dementia	YES/NO	
Heart Problems	YES/NO		Depression	YES/NO	
Blood Pressure	YES/NO		GERD	YES/NO	
Stroke	YES/NO		Headaches	YES/NO	
Aneurysm	YES/NO		Migraines	YES/NO	
Anxiety	YES/NO		Hepatitis A B C	YES/NO	
Arthritis	YES/NO		HIV/AIDS	YES/NO	
Atrial fibrillation	YES/NO		Hyper/hypo-thyroidism	YES/NO	
Blood clots	YES/NO		Kidney disease /failure/ stones/ Infection	YES/NO	
Cancer	YES/NO		MRSA infection(s)	YES/NO	
Pneumonia	YES/NO		Tuberculosis	YES/NO	
Crohns disease	YES/NO		Epilepsy or seizures	YES/NO	

Family History:

Who: Maternal/Paternal			Who: Maternal/Paternal		
	YES/NO	High Blood Pressure		YES/NO	Cancer
	YES/NO	Heart Disease		YES/NO	Asthma/ Lung Disease
	YES/NO	High Cholesterol		YES/NO	Tuberculosis
	YES/NO	Diabetes		YES/NO	Kidney disease/failure
	YES/NO	Stroke		YES/NO	Seizures

Past Medical History; (please list significant illnesses such as pneumonia, or operations e.g. appendectomy with the most recent listed first)

Year	Type	Hospital