Health History

Past Medical History

Have you ever had the following: ***(circle if "yes," leave blank if "no.")***

Diabetes	yes	Anxiety/Depression	yes	Headaches	yes
Cancer	yes	Measles	yes	Tuberculosis	yes
High Blood Pressure	yes	Mumps	yes	Glaucoma	yes
Asthma/Allergies	yes	Chickenpox	yes	Hernia	yes
Stomach Ulcers	yes	Scarlet Fever	yes	Blood Transfusions	yes
Kidney Disease	yes	Pneumonia	yes	Lung Disease	yes
Thyroid Disease	yes	Rheumatic Fever	yes	Hemorrhoids	yes
Heart Disease	yes	Venereal Disease	yes	Spine Trouble	yes
Arthritis	yes	Urine Infections	yes	Hives or Eczema	yes
Anemia	yes	Epilepsy	yes	AIDS or HIV+	yes
Heart Valve Disease	yes	Stroke	yes	Hepatitis	yes

Please explain any of the above "yes" answers When?

_____ _____

_____ _____

_____ _____

Previous Hospitalizations/Surgeries/Serious Illnesses (not listed above) When?

_____ _____

_____ _____

_____ _____

Medications (include non-prescription)

_____

_____

Medication Allergies:_____

Patient Social History

Use of alcohol: Never:_____ Occasional:_____ 1-2 Drinks/day:_____ >2 Drinks/day:_____

Use of tobacco: Never:_____ Previously, but Quit:_____ Current packs/day:_____

Use of drugs: Never:_____ Type/Frequency_____

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____