

# PATIENT HEALTH HISTORY

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

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## FAMILY HISTORY: (circle as many as apply)

Mother: 1) Cancer 2)Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health  
If deceased- Age at death: \_\_\_\_\_

Father: 1) Cancer 2)Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health  
If deceased- Age at death: \_\_\_\_\_

Siblings: 1) Cancer 2)Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

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## SOCIAL HISTORY:

Marital Status: 1) Single 2) Married 3) Divorced 4) Widowed

Number of Children: (None) (1) (2) (3) (4) (5) (6) (7) (8) (9+)

Do You: 1) Exercise regularly 2) Eat a balanced diet 3) Obtain sufficient rest

Do You Smoke-(Packs/day) 1) No 2) Less than 1 3) 1-2 4) 2-3 5) 3-4 6) More than 5

Do You Drink Coffee/Tea- (cups/day) 1) No 2) Occasionally 3) 1-2 4) 2-3 5) 3-4 6) More than 5

Do You Drink Alcohol- (drinks/day) 1) No 2) Occasionally 3) 1-2 4) 2-3 5) 3-4 6) More than 5

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## MEDICAL HISTORY:

Immunizations: (circle) 1) Tetanus 2) Pertussis 3) Diphtheria 4) German Measles 5) Measles 6) Mumps 7) Polio

Childhood Illnesses: 1) Measles 2) Mumps 3) Chickenpox 4) Tuberculosis 5) Rheumatic fever 6) Diabetes 7) Cancer

List any serious childhood illnesses not recorded above.

\_\_\_\_\_ Age: ( )  
\_\_\_\_\_ Age: ( )  
\_\_\_\_\_ Age: ( )  
\_\_\_\_\_ Age: ( )

List any birth defects:

\_\_\_\_\_  
\_\_\_\_\_

Hospitalizations & Surgeries: If you have ever been hospitalized, list reason, and dates.

\_\_\_\_\_ M/D/Y \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_ M/D/Y \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_ M/D/Y \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_ M/D/Y \_\_\_\_/\_\_\_\_/\_\_\_\_

Adult Illnesses/Injuries: List all serious diseases & injuries for which you have not been hospitalized; include approximate dates.

\_\_\_\_\_ M/D/Y \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_ M/D/Y \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_ M/D/Y \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_ M/D/Y \_\_\_\_/\_\_\_\_/\_\_\_\_

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## MEDICATIONS:

Medications: (Include home remedies) List all medications that you are or have taken on a regular basis in the last 6 months.

A) \_\_\_\_\_ B) \_\_\_\_\_

C) \_\_\_\_\_ C) \_\_\_\_\_

Medications to which you are allergic:

A) \_\_\_\_\_ B) \_\_\_\_\_

C) \_\_\_\_\_ C) \_\_\_\_\_