



Health History

Patient Name: _____ Date of Birth: _____

Reason for visit: _____

Medications/Herbals or Vitamins: (name, dosage and directions-feel free to attach a separate list)

Allergies: Medication/Environmental/Food (If Yes, please specify medication and reaction)

Medical History: (please circle Yes or No)

Asthma/Lung Disease	Yes / No	Hypertension	Yes / No
Bleeding/Clotting Disorder	Yes / No	High Cholesterol	Yes / No
Cancer	Yes / No	Autoimmune Disorder	Yes / No
Psychological Disorder	Yes / No	Stroke	Yes / No
Tuberculosis	Yes / No	Osteopenia/Osteoporosis	Yes / No
Neurological Disorder	Yes / No	Heart Disease/Attack	Yes / No
Diabetes	Yes / No	Thyroid Disorder	Yes / No
Hepatitis/Liver Disease	Yes / No	Date of last Colonoscopy:	_____

If you answered yes to any of the above questions, please explain. Include date, treatment received and if available, physician treating the condition:

Have you had a blood transfusion? Yes or No If yes: When? _____

GYN History

Date of last pap: _____ Normal or Abnormal	Length of periods (days): _____
HPV vaccine: _____ Yes or No	Number of days between periods: _____
History of Abnormal Pap Smears: _____ Yes or No	Sexually active: Yes or No
Date of last mammogram: _____ Normal or Abnormal	Your partner(s): Male/Female/Both
Date of bone density: _____ Normal or Abnormal	Birth control method: _____
Age of 1 st period: _____	Age at onset of menopause: _____
Last menstrual period: _____	History of STDs: _____

Pregnancy History

of pregnancies: _____ # of miscarriages: _____ # of abortions: _____
 How many c-sections: _____ How many living children: _____

Surgical History: (what type of surgery and when)

Hospitalizations: (which hospital, when and the reason for admission/ER visit)

If over 65, have you fallen in the past year? If so, what caused the fall(s) (such as dizziness, related to medication, low blood sugar, tripped, etc.)?

Family History:

	Breast Cancer	Ovarian Cancer	Uterine Cancer	Colon Cancer	Osteoporosis	Pancreatic Cancer	Other
All Family							

Social History:

Caffeine (drinks or caffeine containing drugs) Yes / No If Yes: How Much? _____

Tobacco Yes / No If Yes: How much per day? _____ How long used? _____

Alcohol Yes / No If Yes: How much per day? _____ How long used? _____

Drug Use (illicit or non-prescribed) Yes / No If Yes: How often? _____ What type? _____

Domestic Abuse Yes / No If yes: Past or Present

Specialists: (name of physician and condition treated)

Patient (or Responsible Party) Signature: _____

Date: _____