HEALTH HISTORY

Name: **Email:**

DOB: **Home Phone:** **Cell Phone:**

Address:

FAMILY HISTORY: For each member in your family, check the boxes for their present state of health and any illnesses they have now or have ever had.	Good health	Poor health	Deceased	Write in age and cause of death. Include fatal accidents and suicides.	Allergies or Asthma	High cholesterol	Blood clotting problems	Diabetes	Cancer or tumor	Stroke	Glaucoma	Genetic disease	Alcoholism	Kidney or bladder trouble	Stomach/ duodenal ulcer	Mental Illness	Rheumatism or arthritis	High blood pressure	Heart trouble	Dementia	Gout
Father																					
Mother																					
Brother(s):																					
Sister(s):																					
Spouse																					
Child																					
Child																					
Child																					
Child																					
Father's relatives																					
Mother's relatives																					
Your Health History. Have you had:																					

Additional Illnesses or Problems: Please check any of the following you have now or have ever had				
□ eye infections	□ pneumonia	□ neuralgia or neuritis	□ scarlet fever	□ mononucleosis
□ thyroid disease	□ pancreatitis	□ tension/anxiety	□ measles	□ sexually transmitted disease
□ eczema	□ liver disease	□ depression	□ mumps	□ yellow jaundice
□ hives or rashes	□ diverticulosis	□ childhood hyperactivity	□ polio	□ tuberculosis
□ bronchitis	□ hernia	□ chicken pox	□ rheumatic fever	□ high cholesterol
□ emphysema	□ hemorrhoids	□ German measles	□ malaria	□ other (list below)
□ hepatitis	□ blood transfusion	□ drug abuse	□ osteoporosis	

Major Hospitalizations: If you have ever been hospitalized for any major illnesses or operations, please list the most recent below. Please let us know if you have had more than 4 by checking the box □. (do not include normal pregnancies)				
	Year	Operation or Illness	Name of Hospital	City and State
1st Hospitalization				
2nd Hospitalization				
3rd Hospitalization				
4th Hospitalization				

SOCIAL HISTORY	
Tobacco Use	□ Yes □ No If yes, how often and how much do you smoke or use tobacco products?
Alcohol Use	□ Yes □ No If yes, how often and how much do you drink?
Drug Use	□ Yes □ No
Caffeine Use	□ Yes □ No If yes, how many cups?
Exercise	□ Yes □ No □ Occasionally □ Regularly How many days a week?
Marital Status	□ Married □ Separated □ Divorced □ Widowed □ Single
Sexually Active	□ Current □ Not Current □ Never
Sexual Preference	□ Heterosexual □ Homosexual □ Bisexual □ Other
Number of Sexual Partners-life?	

ALLERGIES
Please list all allergies and the reaction you had. If no allergies just mark NKA.
□ NKA (no known allergies)

MEDICATIONS
Please list all medications, vitamins, and supplements you are taking.

How did you hear about our practice?

___ Physician Referral, please specify:_____
___ Internet Advertising
___ Print Advertisting, please specify: _____
___ Billboard
___ Google or Online search
___ Event/Health Fair
___ Word of Mouth
___ Family/Friend
___ Other