

HEALTH HISTORY

Date	Patient's Name	Date of Birth	Age

1. List any current or past medical problems, surgeries, or hospitalizations that you have/had: *including problems for which you are currently taking any medication (use separate sheet if necessary)*

_____	_____
_____	_____
_____	_____
_____	_____

2. What particular symptoms do you want to address today?

_____	_____
_____	_____

3. List medications, dose and how often you take it: *including over the counter (OTC) medications and supplements (use separate sheet if necessary)*

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Allergies to medications: *including type of reaction*

_____	_____
_____	_____

5. Family History: List any medical problems in your parents or siblings. *Example: diabetes, heart disease, stroke, cancers, etc*

_____	_____
_____	_____

6. Social History:

Married?	Children?	Work?	Hobbies?

7. Preventive: *Please list the date of your last*

Colonoscopy	Immunizations (<i>Tetanus, Pneumovax, Shingles, etc</i>)	Eye Exam

Women	Mammogram	Pap	Breast Exam
Men	PSA	Rectal Exam	

8. Have you ever smoked?

- No, never
 Yes, and I am currently smoking (see following questions)
 Yes, and I am *not* currently smoking (see following questions)

How many packs per day? How many years? When was the last time you quit?

9. Do you drink alcohol?

- No Yes

How much and how often?

(example - glass of wine with dinner 7 days week)

10. What *non* alcoholic beverages do you drink most commonly?

11. Describe your diet and exercise routine for the last three days:

Day	Breakfast	Lunch	Dinner	Snacks	Beverages	Exercise
1						
2						
3						