



HEALTH HISTORY FORM

Date: _____

Name: _____

Birth date: _____

Marital Status: Single Married Separated Divorced Widowed Other

Education Level: Grade School High School College Advanced Degree

Occupation: _____ Please describe work: _____

Hobbies: _____

Medication Allergies (include reaction): _____

Current Medications and Dosage (include non-prescription):

_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Hospitalizations/Surgeries:

Date:	Reason/Event

NAME: _____

DOB: _____

Family History:

	AGE (or age at death)	Medical Conditions or Cause of Death
Father	_____	_____
Mother	_____	_____
Brothers	_____	_____
	_____	_____
Sisters	_____	_____
	_____	_____
	_____	_____

Immunization History:

When did you last have these immunizations?

Tetanus _____

Pneumonia _____

Hepatitis B _____

Has any family member had:

YES	NO		YES	NO	
		Cancer of the breast			Heart disease
		Cancer of the colon			Depression
		Cancer of the prostate			Other mental illness
		High blood pressure			Alcoholism
		Diabetes			

Health Risks:

YES	NO	
		Do you smoke? If yes, how many packs per week?
		Do you chew tobacco?
		If you drink alcohol, how much? what type?
		Have you ever used intravenous drugs or received a blood transfusion?
		Are you concerned about your risk of HIV (AIDS)?
		If you ride a bicycle or motorcycle, do you wear a helmet?
		Do you use seatbelts regularly?
		Do you use sunscreen most of the time?
		Does your home have a smoke alarm?
		Do you exercise often? If yes, how often? what type?

NAME: _____

DOB: _____

Symptoms or Concerns:

YES	NO	
		Any skin problems?
		Any suspicious skin lesions?
		Any eye problems?
		Glaucoma or persistent eye pain?
		Wear contact lenses or glasses?
		Any hearing or ear problems?
		Frequent nose bleeds, recurrent sinus pain or congestion?
		Any dental disease or wear dentures?
		Any trouble breathing, shortness or breath, chronic cough?
		Any unusual hoarseness?
		Ever exposed to tuberculosis or have positive skin test or chest x-ray?
		Any heart problems?
		Do you develop chest pain with exertion?
		Frequent swelling of feet?
		Ever blood clots in legs or lungs?
		Ever rheumatic fever?
		Does walking cause pain in the legs?
		Any problems with digestion or movements?
		Difficulty swallowing?
		Heartburn or nausea?
		Ever had an ulcer?
		Any problems with urination?
		Trouble emptying bladder, leaking urine?
		Ever have a kidney stone?
		Any arthritis or joint pain? Where?
		Recurrent back problems?
		Other bone or joint problems?
		Troubled by headaches?
		Ever lost consciousness or had seizure?
		Any trouble sleeping?
		Difficulty concentrating?
		Troubled by depression?
		In the last year, any unexplained change in weight?
		Unusual heat or cold sensitivity?
		Ever a thyroid problem?

NAME: _____

DOB: _____

QUESTIONS FOR MEN ONLY:

YES	NO	
		Any lumps or pain of the testicles?
		Any problems with erections or sexual intercourse?
		Ever any sexually transmitted diseases?
		Ever have same-sex sexual activity?
		Any questions about when or how to examine your testicles?

QUESTIONS FOR WOMEN ONLY:

How many times pregnant? _____ How many children? _____

What method of contraception do you use? _____

Any lumps, pain, discharge or skin changes of the breast? _____

Any questions about when or how to examine your own breasts? _____

Any problems with menstrual cycles? _____

Age at onset _____ years old. Length (from start to start) _____

Usual duration of flow _____ days. Date of start of last flow _____

Date of last Pap smear _____ Ever an abnormal Pap? _____

Did your mother take DES when pregnant with you? _____

Ever any pelvic or vaginal infections? _____

Any usual vaginal discharge or itching? _____

Any prior sexually transmitted diseases? Yes _____ No _____

Any symptoms of menopause? Yes _____ No _____

QUESTIONS FOR THE ELDERLY:

YES	NO	
		Have you fallen lately?
		Would you like to discuss a living will?