Patient Name:_____ | DOB:__/__/____

PERSONAL HEALTH HISTORY

List of any medical problems that other doctors have diagnosed:

SURGERIES /OTHER HOSPITALIZATIONS		
Year	Reason	Hospital

Medications:	Dose:	Prescriber:
Allergies to Medications:	Reaction	

Last Physical Exam: _____

Last Colonoscopy: _____

Last Mammogram (Women): _____

Last Dexa Scan (Women): _____

Last Pap Smear (Women):_____

Immunizations & dates	__ Tetanus	__ Pneumonia
	__ Hepatitis	__ Shingles
	__ Influenza (year:_____)	__ MMR

Patient Name:_____ **DOB:__/__/___**

Have you ever had:								
yes	no		yes	no		yes	no	
		Eye/vision problems			High blood pressure			Pain with intercourse
		Ear/hearing problems			Frequent indigestion			Abnormal periods
		Severe nose bleeds			Stomach pain			Back trouble
		Throat trouble			Black/bloody stool			Neck trouble
		Sinusitis			Jaundice			Arthritis / joint pain
		Recurrent cough			Hernia			Skin trouble
		Hay fever/Allergies			Frequent urination			Frequent headaches
		Asthma			Awaken to urinate			Seizures
		Trouble swallowing			Urine leakage			Depression
		Fainting spells			Kidney stones			Anxiety/panic attacks
		Chest pain			STDs			Anemia
		Irregular heart beat			Erection issues			Weight loss or gain
		Ankle swelling			Breast lump/discharge			Bleeding problems
		Leg cramps			Abnormal pap smear			Diabetes

SOCIAL HISTORY

Occupation:_____

Living Situation:

__ Married	__ Single	__ Divorced	__ Kids (# ___)	__ Pets

Tobacco	No longer/former ____	___ Cigarettes/Pipe (____ packs/year)
	Never ____	___ Chew (___ Times/day)
Alcohol	No ____	___ Yes (____ drinks/week)
Recreational Drugs	No ____	___ Yes
Exercise	__ Sedentary (no exercise)	
	__ Mild Exercise (stairs, walking a few times a week)	
	__ Occasional Vigorous exercise (work/recreation, less than 4x/week for 30+ min)	
	__ Regular vigorous exercise (work/recreation, 4x/week for 30+min)	

FAMILY HISTORY (check what applies)

MOTHER	FATHER	SIBLINGS	OTHER
Diabetes ☐	Diabetes ☐	Diabetes ☐	Diabetes ☐
Cardiovascular Disease ☐	Cardiovascular Disease ☐	Cardiovascular Disease ☐	Cardiovascular Disease ☐
Hypertension ☐	Hypertension ☐	Hypertension ☐	Hypertension ☐
Stroke ☐	Stroke ☐	Stroke ☐	Stroke ☐
Cancer ☐	Cancer ☐	Cancer ☐	Cancer ☐
Other:	Other:	Other:	Other

SIGNATURE: _____

Date: _____