



Name: \_\_\_\_\_  
DOB: \_\_\_\_\_

## PATIENT HEALTH HISTORY

Date: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_

### PAST MEDICAL HISTORY

#### Surgeries: (Type and Year)

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

#### Hospitalizations: (Reason and Year)

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

#### Long Standing Medical Problems:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

#### Current Medications: (Include dose and frequency, if known)

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

#### Allergies: (Include medications, food and environmental)

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

#### Family History: (Please check appropriate)

<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Alcohol/Drug Abuse
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke	Other: _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Problems	

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date