

HEALTH HISTORY SHEET

Welcome to our practice! To provide you with the best, most comprehensive care possible, we request that you provide the following information. All information is held strictly confidential and is released only with your written permission.

Last Name:		First:		Age:		Sex:		Doctor Notes <i>please do not write in this area</i>	
Presenting Problem or Proposed Surgery:									
Have you or any blood relative had:									
	Yes	No	Who		Year				
Allergies, asthma, hay fever									
Anemia									
Alcoholism									
Arthritis									
Bleeding problems									
Birth defects									
Cancer									
Emphysema									
Epilepsy or seizures									
Heart Trouble									
Mental illness									
Migraine headaches									
Rheumatic fever									
Stroke									
Suicide									
Thyroid disease/goiter									
Tuberculosis									
Ulcers									
Venereal disease									
Osteoporosis									
Glaucoma									
Gallstones									
Have you ever been turned down for military, job, insurance?						Yes	No		
Names of Other Present MDs		Last Visit		Childhood Immunizations		Year			
				Tetanus					
				Childhood Diphtheria					
				Childhood Polio					
				Pneumovax					
				Flu Shot					
				Last TB Test					
				TB:		Positive	Negative		
ALLERGIES: Please list type and reaction								NONE	
Name of Drug/Item		Reaction		Name of Drug/Item		Reaction			

HEALTH HISTORY SHEET

Patient Name: _____

MEDICATIONS						Doctor Notes <i>do not write in this area</i>
Have you EVER TAKEN:	Yes	No	Year	How Long?	Brand/Descr/Dose	
Blood pressure pills						
Cortisone/steroids						
Diet pills						
Diabetes pills						
Thyroid pills						
Tranquilizers						
Water pills						
Are you NOW taking:						
Antacids						
Aspirin						
Antibiotics						
Birth control pills						
Blood thinner pills						
Laxatives						
Pain pills						
Sleeping pills						
Vitamins						
OTHER <i>Please list</i>						
OB/GYN HISTORY				Date or no. if requested	Yes	
Date of last menstrual period:						
Are your menses irregular?						
No. of days between periods						
No. of days periods last						
Spotting between periods?						
Do you forget to do self breast exams monthly?						
Are you pregnant						
No. of pregnancies						
Date of last pregnancy						
No. of live births						
No. of abortions or miscarriages						
Date of last Pap smear						
Was it abnormal?						
Have you ever had any other abnormal Pap?						
Are you currently using contraception?						
Type of contraception						
Types of contraceptives used in past						
Did your mother take DES during her pregnancy?						
Over 1 year since last mammogram? If yes, date:						
SURGICAL HISTORY: Name of Operation		Date	Complications			
Have you ever had bleeding problems?		Yes	No			
Have you ever had a blood transfusion?		Yes	No Date: _____			
MAJOR ILLNESS OR INJURY: list any illness or injury requiring hospitalization, prolonged care, or use of medication. Include approximate date. _____						

HEALTH HISTORY SHEET

Patient Name: _____

PERSONAL HABITS/RISK FACTORS				Doctor Notes <i>please do no write in this area</i>
	Yes	No	Answers	
Do you smoke or chew tobacco?			No. packs/day:	<p><i>If there are any special concerns you would like to discuss with the doctor, please continue on the reverse of this sheet. Thank you for providing us with this important information.</i></p>
Have you ever smoked in the past?			Date started:	
			Date stopped:	
Do you often miss 3 meals/day?				
Do you eat snacks regularly?				
Do you have an eating problem?				
Any diet preferences/restrictions?				
Type				
Dietary habits			Frequency or No.:	
Low fat				
No. servings/day vegetables/fruits				
No. servings/day grains				
No. times/week you eat red meat				
No. servings/day dairy				
No. caffeine drinks/day				
Ave. alcoholic drinks/day				
No. times "drunk"/year				
Ever had a drinking problem?				
Ever had a drug problem?				
Every used intravenous drugs?			Date last used:	
Do you ever not use seat belts?				
No. hours sleep/day				
Highest grade level achieved				
Do you not know how to swim?				
Do you not exercise regularly?				
What exercise do you do?				
How often/week?			Duration:	
What do you do to relieve stress?				
Any pets?				
Any hobbies?				
Occupation:				
Do you hate your job?				
Is your job a risk to your health?				
If yes (in any way), please explain:				
SOCIAL HISTORY			Do you have children?	
Are you: Married			Yes No	
Divorced Single			If yes, please list No. & age(s)	
Widowed Living with "signif. other"				
SEXUAL HISTORY		Yes No	Sexual partners in past year:	
Are you sexually active?			No. men	
Is sex unsatisfactory in any way?			No. women	
History of Chlamydia?			No. unprotected	
Gonorrhea?			AIDS, cont'd	
Venereal warts?			Would you like to have a test?	
Are you concerned about AIDS?			Yes No	