Health History Form

Name:________________________________**DOB:**______________**Sex:** ☐ Female ☐ Male **Date:**____________

Reason for today's visit ____

Personal Health History

Childhood Illnesses:____

____

Immunizations and Dates: ☐ Tetanus ☐ Influenza ☐ Pneumonia

Social History: Do you smoke?________ If yes, how much?________________________

If no, when did you quit?__________________

Do you drink?_________ If yes, how much?________________________

If no, when did you quit?__________________

Drug Allergies:____

Surgeries and Hospitalizations	
Year	Reason

Family Health History					
	Age	Significant Health Problems		Age	Significant Health Problems
Father			Children	☐ Female ☐ Male	
Mother			Children	☐ Female ☐ Male	
Siblings	☐ Female ☐ Male		Children	☐ Female ☐ Male	
Siblings	☐ Female ☐ Male		Grandparents Maternal	☐ Female ☐ Male	
Siblings	☐ Female ☐ Male		Grandparents Paternal	☐ Female ☐ Male	

Medications		
Name:	Strength/Dosage:	Frequency:

Other Medical Problems		
Check if you have or had any symptoms in the following areas to a significant degree and briefly explain.		
☐ Skin	☐ Chest/Heart	☐ Recent Change in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy Level
☐ Nose	☐ Bladder	☐ Ability to Sleep
☐ Throat	☐ Bowel	☐ Other:
☐ Lungs	☐ Circulation	

________________________________ ________________________________

Patient Signature *Physician Signature*