Name:______________________ Birthdate:____________________ Date:______________________

Sex:________ Race:______________

Height______________

Weight______________

Health History of the Patient

	Yes	No
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis Type________		
Gout		
Seizures		
Mental Illness		
Kidney Trouble/Stones		
Cancer Type________		
Bleeding disorders		
Alcoholism		
Serious injuries		
Lung disease		
Tuberculosis		
Phlebitis		
Anemia		
Stomach ulcers		
Liver trouble		
Thyroid trouble		
HIV		
Hepatitis		
Osteoporosis		
Other Illnesses		

Explain all Yes answers:

____

____

____

List all Surgeries (include approx. dates)

____

____

____

____

Allergies to Medicine (None)

____

____

____

____

Family History

	Yes	No
Stroke		
Heart trouble		
High blood pressure		
Diabetes		
Arthritis		
Gout		
Seizures		
Mental Illness		
Kidney trouble/stones		
Cancer		
Bleeding disorders		
Alcoholism		
Other		

Explain all Yes answers:

____

____

____

Cause of death parents, brother or sisters

____

____

____

____

Current Medications/Vitamins/Supplements and dosage:

____

____

____

____

____

____

____

	YES	NO
Weight Loss or Gain		
Rash or Itching		
Change in Vision		
Abnormal Heartbeat		
Heart or Chest pain		
Shortness of Breath		
Fever		
Abdominal Pain		
Diarrhea		
Nausea or Vomiting		
Bowel/Bladder incontinence		
Frequent urination		
Burning on urination		
Urination Urgency		
Muscular Weakness		
Joint Pain		
Joint Swelling		
Numbness		
Bleeding Tendency		
Lymph Node Enlargement		

Social History

Most recent occupation/grade in school

____

____

☐ Married ☐ Single

☐ Divorced ☐ Widowed

Number of children ____________

Presently living alone? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Smoke______ packs per day

Alcohol: ☐ Never ☐ Occasional

☐ Moderate to Heavy

Do you use illegal drugs ☐ Yes ☐ No

Patient Signature

____

MD Initials ______________