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HEALTH HISTORY INTAKE FORM

Patient Name ______________________________________ **Birth Date:** ______________________________

Please answer all of the questions as accurately as possible. If you do not understand the question, ask for assistance.

Chief Complaint(why are you here?):____

Primary Care Doctor: ____**Date last physical exam:**____________

Drug allergies:____**Latex...no yes / Betadine..no yes**

Anesthesia reaction/problems:__________ **Sleep Apnea ……no yes -- if yes, do you use a CPAP** _____

List previous surgeries or major illnesses and dates: ____

____

List any medications you are taking, including non-prescription drugs, vitamins, and herbals:

____

Social History:

Smoking (type and amount per day) __________ Alcohol(type and amount per week) ______________________

If former smoker, date quit: __________________ Weight ____________ Height ______________ BMI_______

Family History: Has any blood relative ever had the following:

Breast Cancer …………	no	yes	High Blood Pressure ...	no	yes	Kidney Disease ……...	no	yes
Ovarian Cancer ………	no	yes	Heart Disease ……..…	no	yes	Depression ………...…	no	yes
Stroke ………………..…	no	yes	Diabetes ………………...	no	yes	Melanoma ……………	no	yes

Past Medical History: Have you ever had the following:

Heart Disease ………..	no	yes	Diabetes ……………...	no	yes			
Chest Pain …………...	no	yes	Cancer ……………….	no	yes	Stomach Ulcer …..…...	no	yes
Blood Clots ………..…	no	yes	Glaucoma ……...….…	no	yes	Kidney Disease …..….	no	yes
Arthritis ………………	no	yes	Asthma ...……………	no	yes	Thyroid Disease …..…	no	yes
Rheumatic Fever …….	no	yes	AIDS or HIV …………	no	yes	Bleeding Tendency ….	no	yes
Anemia ………………	no	yes	Stroke …………………	no	yes	Mitral Valve Prolapse .	no	yes
Tuberculosis …………	no	yes	Hepatitis …..…………	no	yes	High Blood Pressure ...	no	yes

Gastric Reflux ……… no yes -- if yes -- are you on medication for this?(name) ____________________________

Review of Systems: Do you have now or have you had within the past year:

Constitutional:			***Skin:***			***Neurological:***		
Weight Change ……...	no	yes	Skin rash …………..……	no	yes	Seizures ..……………	no	yes
EENT:			***Gastrointestinal:***			***Musculoskeletal:***		
Dry Eyes …………….	no	yes	Chronic Diarrhea ….	no	yes	Joint or Muscle Pain ..	no	yes
Respiratory:			Jaundice …………...	no	yes	***Lymphatic***:		
Chronic Cough ……...	no	yes	***Psychiatric:***			Swollen Lymph Nodes.	no	yes
Cardiovascular:			Depression ………...	no	yes	***Hematologic:***		
Chest Pain ……………	no	yes	***Genitourinary***:			Easy Bleeding ..……..	no	yes
Rapid Heart Beat ……	no	yes	Kidney/			Easy Bruising ……...	no	yes
Swollen feet/ankles ….	no	yes	Urinary Problems ….	no	yes	Phlebitis, blood clots ..	no	yes

Women Only: Birth control pills …… no yes

Last menstrual period:___________________

Number of children:_________________

Number of pregnancies:__________________

Date of last mammogram_____________

Did you breast feed? no yes

Do you do regular breast self-examinations? no yes

Breast lump or discharge no yes

I VERIFY THAT THIS HEALTH HISTORY IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X____ ____

Signature of patient or guardian Date

(above information is to be updated annually)