

Health History Information

Patient Name: _____ Date: _____

Reason for visit: _____

Age: _____ Height: _____ Weight: _____

Other physicians you see: _____

Allergies to medications: _____

Please list all medications you are currently taking:

Medication	Dose	Directions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST MEDICAL HISTORY

SURGERY	YES	NO	SURGERY	YES	NO
Eyes, ears, nose			Breast		
Tonsils/adenoids			Pregnancy		
Thyroid			Gallbladder		
Heart			Hysterectomy		

Please list any other surgeries: _____

ILLNESS	YES	NO	ILLNESS	YES	NO
Diabetes			Blood clots		
Hypertension			Cancer/Type		
Heart disease			High cholesterol		
Liver disease			Mental illness		
Thyroid disease			Bleeding disorder		
Stroke					

Please list any other illnesses: _____

LIFESTYLE	YES	NO	LIFESTYLE	YES	NO
Alcohol use			Past/current drug use		
Tobacco use			S.T.D.		

FAMILY HISTORY	YES	NO	RELATION	FAMILY HISTORY	YES	NO	RELATION
Cancer & type				T.B.			
Diabetes				Mental illness			
Heart disease				Epilepsy			

