PATIENT HEALTH HISTORY

Please answer the following questions prior to your first examination. **Date:** _____

Name	Date of Birth	Age		Male / Female	Religion
Occupation	Shift Worked: ____Day ____Night ____Both			How Long?	Education (highest level)
Reason for visit?				Address change since last year?	

PERSONAL HEALTH HISTORY (Check all that apply)					
	Anemia		Digestive Problems Ulcers		High Blood Pressure
	Arthritis/Gout		Dizzy/Fainting Spells		Bladder Problem
	Asthma/Pneumonia		Frequent Urinary Infections		Kidney/Prostate Problems
	Back Problem		Glaucoma/Cataracts		Shortness of Breath
	Cancer		Headaches		STD's (sexually transmitted disease)
	Chest Pain/Pressure		Heart Attack/Disease		Stroke
	Depression		Hemorrhoids		Thyroid Problem
	Diabetes		Hepatitis		TB/Lung Disorder

SURGERY HISTORY (Check all that apply and list the year)								
	Amputation			Gallbladder			Stomach	
	Appendix			Hernia			Thyroid	
	Back			Hemorrhoid			Tonsils	
	Breast			Hysterectomy			Tubal Ligation	
	Cataract ___R ___L ___Both			Prostate			Vasectomy	
	Heart Surg/Angioplasty			Removal of Ovaries			Other: _____	

WOMEN ONLY					
	Abnormal PAP Smear		Vaginal Discharge	Age Period Began:	
	Bleeding Between Periods		Painful Intercourse	Usual Duration (Days):	
	Breast Lump		Start Date of Last Period	Periods Regular: ____Yes ____No	
	Extreme Menstrual Pain		Date of Last PAP Smear	Menstrual Flow: ____Heavy ____Mod ____Light	
	Hot Flashes		Other: _____	Are you Pregnant? ____Yes ____No	
	Nipple Discharge			Number of Children:	

IMMUNIZATIONS (Dates, if available)				Health Habits (check used and how much)	
	DPT		OPV (Polio)		Caffeine
	Flu		Pneumonia		Drugs
	Hepatitis		PPD		Tobacco
	HIB		Tetanus		Electronic Cigarettes
	MMR		Other: _____		Other: _____

FAMILY HISTORY		
Relationship	**Health Problem(s)**	**If Deceased, cause and age**
Father		
Mother		
Father's Parents		
Mother's Parents		
Brothers / Sisters		

Medications (list frequency, dosage, and years of usage)	Allergies

Provider's Signature: _____ **Date:** _____

Revised 10/10/2014