HISTORY FORM

Patient Name:_____ Date of Birth:_____

Do you have any food or medication allergies? ☐ No ☐ Yes, Please list:_____

_____

Are you taking any medication?: ☐ No ☐ Yes, *Please list all medications including over the counter, supplements and herbs.*

MEDICATION HISTORY

Name of Drug	Dose	How taken

PAST MEDICAL HISTORY

Please check all that apply

☐ Allergy	☐ Fatigue	☐ Sleep Disorder	☐ Cancer, Lung
☐ Anemia	☐ Foot Problems	☐ Stroke	☐ Cancer, Breast
☐ Anxiety Disorder	☐ Headache	☐ Thyroid Disorder	☐ Cancer, Colon
☐ Arthritis	☐ Hearing Loss	☐ Weight Issues	☐ Cancer, Prostate
☐ Asthma	☐ Heart Disease	☐ Infectious Disease	☐ Cancer, Skin
☐ Breathing Difficulties	☐ High Blood Pressure	☐ Sexually Transmitted Disease	☐ Cancer, Brain
☐ Bladder Problems	☐ High Cholesterol	☐ Gynecological Problems	List other Cancer Below:
☐ Colon Disorder	☐ Kidney Disease	List Other Problems Below:	
☐ Diabetes	☐ Lung Disease		
☐ Bowel Problems	☐ Memory Loss		
☐ Depression	☐ Pain, Back		
☐ Eye Disease	☐ Pain, Joint		
☐ Erectile Dysfunction	☐ Pain, Hip		

☐No Significant Medical History to Report

PAST SURGERIES OR HOSPITALIZATIONS

Please list past Surgeries and Hospitalizations:

Past Surgery:	**Date**
Previous Hospitalizations:	**Date**
☐ None to report	

SOCIAL HISTORY

☐ Non Smoker	☐ Smoker, # of packs per day? _____ # of years? _____	☐ Previous Smoker	☐ Other Tobacco Products

Drink Alcohol ☐No ☐ Yes ☐ < 5 drinks per week ☐ > 5 drinks per week ☐ Socially

FAMILY HISTORY

List family member with the following condition(s)

	Relationship		**Relationship**		**Relationship**
☐ Heart Disease		☐ Kidney Disease		☐ Dementia	
☐ High Blood Pressure		☐ Diabetes		☐ Other	
☐ High Cholesterol		☐ Lung Disease			
☐ Thyroid Disease		☐ Mental Illness			
☐ Arthritis		☐ Cancer			

IMMUNIZATION HISTORY

Did you receive all childhood vaccinations? ☐ No ☐ Yes

Recent Vaccinations	**Date Given**
☐ Pneumococcal Vaccine	
☐ Influenza Vaccine	
☐ Shingles Vaccine	
☐ Tetanus Booster	
☐ TdaP	
☐ Hepatitis A Series	
☐ Hepatitis B Series	
☐ TB Skin Testing	Results: ☐ Positive ☐ Negative

HEALTH MAINTENANCE

Recent Screening	**Date Last Screened**
☐ PAP Smear	
☐ Mammogram	
☐ Colonoscopy	
☐ Bone DEXA Scan	

I affirm that the information I have given is correct to the best of my knowledge. It will be held in strictest confidence, and it is my responsibility to inform this office of any change in my medical status.

Signature_____ Date_____

Reviewed with patient_____ Date_____