



Patient Health History

In order to treat you safely and effectively, please answer the following questions. This is for our records only and responses are confidential.

Last Name _____ **First Name** _____ **Middle Initial** _____

Sex ___ M ___ F **Birthdate** _____ **Age** _____ **Today's Date** _____

Your Primary Care Physician is: (name, address & phone) _____

Your Pharmacy is: Name _____ City _____ Phone (____) _____

What concerns bring you in today? (Chief complaint) _____

Allergies to medication(s) ___ Yes ___ No (Please specify) _____

Medications: (Please include herbal supplements, vitamins, non-prescriptions medications and birth control pills, write "None" if none) _____

Do you have any of the following? (Please answer yes or no or family on each line listed below - do not leave any blank.):

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Fevers/Chills	<input type="checkbox"/>	<input type="checkbox"/>	Joint Aches	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>	Leg Swelling (edema)	<input type="checkbox"/>	<input type="checkbox"/>
Stomach (ie: ulcers, acid reflux, pain)	<input type="checkbox"/>	<input type="checkbox"/>	Depression or Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Problems (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Past Medical History / Family History

<u>Disease</u>	<u>Yes</u>	<u>No</u>	<u>Family</u>	<u>Disease</u>	<u>Yes</u>	<u>No</u>	<u>Family</u>
Malignant Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Basal or Squamous Cell Carcinoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal moles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies or Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve Rplacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List prior SURGERIES (Write "None" if none) _____

If you are Female: Are you Pregnant? ___ Yes ___ No Actively trying to become pregnant? ___ Yes ___ No
Breast Feeding? ___ Yes ___ No

Do you drink Alcohol? ___ Yes ___ No # drinks/week _____ **Do you Smoke?** ___ Yes ___ No (how often?) _____

Marital status ___ Single ___ Married ___ Divorced ___ Widowed **Occupation** _____

Patient Signature _____ **Date** _____