PATIENT HEALTH HISTORY

Patient Name: _____ Family Physician: _____

FAMILY HISTORY: (Check only those that apply)

Mother: ☐ Cancer ☐ Diabetes ☐ Heart Problems ☐ High Blood Pressure ☐ Respiratory Problems
☐ Kidney Problems ☐ Stroke ☐ In Good Health ☐ Deceased (if so at what age) _____

Father: ☐ Cancer ☐ Diabetes ☐ Heart Problems ☐ High Blood Pressure ☐ Respiratory Problems
☐ Kidney Problems ☐ Stroke ☐ In Good Health ☐ Deceased (if so at what age) _____

Siblings: ☐ Cancer ☐ Diabetes ☐ Heart Problems ☐ High Blood Pressure ☐ Respiratory Problems
☐ Kidney Problems ☐ Stroke ☐ In Good Health ☐ Deceased (if so at what age) _____

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of Children _____

Do you exercise? ☐ Regularly ☐ Every now and then ☐ Weekend Warrior ☐ Never
Are you interested in an exercise program if it helps your condition? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes: ☐ less than 1 ☐ 1–2 ☐ 3–4 ☐ 5+ packs per day
Do you drink coffee/tea? ☐ Yes ☐ No If yes: ☐ less than 1 ☐ 1–2 ☐ 3–4 ☐ 5+ cups per day
Do you eat a balanced diet? ☐ Yes ☐ No
Do you obtain sufficient rest/sleep? ☐ Yes ☐ No ☐ Most of the time
Do you drink soda? ☐ Yes ☐ No If yes: ☐ less than 1 ☐ 1–2 ☐ 3–4 ☐ 5+ 12 oz. per day
Do you drink alcohol? ☐ Yes ☐ No If yes: ☐ less than 1 ☐ 1–2 ☐ 3–4 ☐ 5+ 12 oz. per day

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MEDICAL HISTORY:

Childhood Illnesses: ☐ Measles ☐ Mumps ☐ Chicken Pox ☐ Tuberculosis ☐ Rheumatic Fever ☐ Diabetes
List any serious childhood illnesses not listed above:

_____ AGE _____
_____ AGE _____
_____ AGE _____
_____ AGE _____

LIST ANY BIRTH DEFECTS: _____
_____

HOSPITALIZATIONS & SURGERIES: List conditions, reasons, and dates

_____ mm/dd/yy _____
_____ mm/dd/yy _____
_____ mm/dd/yy _____
_____ mm/dd/yy _____

ADULT ILLNESSES & INJURIES: List all serious diseases & injuries for which you have NOT been hospitalized, include approximate dates

_____ mm/dd/yy _____
_____ mm/dd/yy _____
_____ mm/dd/yy _____
_____ mm/dd/yy _____

MEDICATIONS: List all medications you are taking or have taken on a regular basis in the last six months (include vitamin/herbal supplements, etc.)

_____ _____ _____ _____
_____ _____ _____ _____

ALLERGIES AND MEDICATIONS TO WHICH YOU ARE ALLERGIC:

_____ _____ _____ _____
_____ _____ _____ _____