



HEALTH HISTORY SHEET

Welcome to our practice! To provide you with the best, most comprehensive care possible, we request that you provide the following information. All information is held strictly confidential and is released only with your written permission.

Last Name:	First:	Age:	Sex:	PROVIDER NOTES Please do not write in this area	
Reason for today's visit:					
PAST ILLNESS: Please indicate if you have been diagnosed with these conditions:					
	Y	N		Y	N
High blood pressure			Migraine headaches		
Angina/chest pain			Epilepsy		
Heart attack			Stroke		
Heart murmur			Glaucoma		
Irregular heart rate			Ulcers		
Asthma			Gallstones		
Emphysema			Diverticulitis		
Tuberculosis			Hepatitis		
Diabetes			Cancer (elaborate below)		
Thyroid disease			Osteoporosis		
Kidney disease/failure			Mental illness		
Please indicate other known medical problems:					
Please list operations that you have had					
Operation:				Year:	
				Y	N
Have you ever had any bleeding problems?					
Have you ever had a blood transfusion?					
Have you had any anesthesia problems?					
Do you have any metal implants?					

Patient Name:

DRUG ALLERGIES: Please list medication and reaction No known drug allergy

Name of drug **Reaction**

Do you have an allergy to LATEX? yes no

MEDICATIONS (prescribed, over the counter, vitamins or supplements)

	Y	N
Do you take aspirin or plavix?		
Do you take ibuprofen or other anti-inflammatory medications frequently?		
Do you take a blood thinning medications?		

PERSONAL HABITS/RISK FACTORS:

Do you smoke? yes no How many packs/day?

Have you ever smoked? yes no Date stopped:

Do you drink alcohol? yes no Frequency? Amount?

FAMILY HISTORY (please indicate conditions such as heart disease, stroke, cancer, blood disorders):

PROVIDER NOTES

Please do not write in this area

SOCIAL HISTORY:

Are you: married divorced single widowed

Who do you live with?

Do you have a living will? yes no

Are there any special concerns you would like to discuss? If so, please continue on the reverse.

Patient Name:						
REVIEW OF SYSTEMS: Please indicate all that apply to you					PROVIDER NOTES Please do not write in this area	
Constitutional symptoms	Y	N	Head and Neck	Y		N
Weight gain/loss			Dizziness/vertigo			
Fevers			Double vision			
Night Sweats			Any vision changes			
Fatigue			Nose bleeds			
Loss of appetite			Sore throat/pain swallowing			
Cardiac	Y	N	Respiratory	Y		N
Chest pain/heaviness			Cough			
Shortness of breath with activity			Wheeze			
Shortness of breath at rest			Shortness of breath			
Irregular heart beat/palpitations			Blood in sputum			
Lightheadedness/fainting			Early waking/snoring			
Gastrointestinal	Y	N	Genitourinary	Y		N
Abdominal pain			Frequent voiding			
Nausea/vomiting			Pain with voiding			
Heartburn			Blood in urine			
Constipation or diarrhea			Sexual dysfunction			
Blood with stools			Groin pain			
Endocrine	Y	N	Hematologic	Y	N	
Heat/cold intolerance			Abnormal bleeding/bruising			
Excessive thirst			Clotting problems			
Excessive voiding			Transfusion problems			
Excessive appetite			Anemia			
Excessive hair growth			Blood clots			
Musculoskeletal	Y	N	Neuro-psychiatric	Y	N	
Joint pain/swelling			Seizures			
Stiffness			Numbness			
Weakness of limbs			Weakness			
Back pain/sciatica			Depression			
Gout			Anxiety			
ObGyn	Y	N	Breast Health	Y	N	
Pregnancies? Live births			Breast cysts/lumps			
C-section?			Breast skin changes			
Menstrual period regular/irreg			Nipple discharge			
Postmenopausal			Breast pain			
Recent PAP smear			Recent mammogram			

Thank you for providing us with this important information

Signature: _____

Date: _____