



PATIENT HEALTH HISTORY

PATIENT NAME: _____ **AGE:** _____

Please answer all of the questions as accurately as possible. If you do not understand the question, please ask for assistance.

Primary Care Doctor: _____

Smoking (type & amount per day) _____ Alcohol (type & amount per week) _____

If former smoker, date quit: _____ Weight _____ Height _____

Drug allergies and reactions: _____

List previous surgeries or major illnesses and dates: _____

List any medications you are taking, including non-prescription, vitamins and herbals: _____

Family History:

Has any blood relative ever had the following? (check all that apply):

Breast Cancer	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>

Past Medical History:

Have you ever had the following?: (check all that apply)

Heart Disease	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	AIDS or HIV	<input type="checkbox"/>	Bleeding Tendency	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>				

Review of Symptoms:

Do you have or have you had within the past year: (check all that apply)

Weight Changes	<input type="checkbox"/>	Swollen feet/ankles	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Dry Eyes	<input type="checkbox"/>
Skin Rash	<input type="checkbox"/>	Joint/Muscle Pain	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	Chronic Diarrhea	<input type="checkbox"/>
Swollen Lymph Nodes	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>
Rapid Heart Beat	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>		

Women Only:

Date of last mammogram _____

Do you do regular breast self-exams? ___ Yes ___ No

Have you had a breast lump or discharge? ___ Yes ___ No

Did you breast feed? ___ Yes ___ No

Bra size _____

Have you had/or plan to have any:

Chemotherapy ___ Yes ___ No

Radiation ___ Yes ___ No

Date of last Treatment _____

I verify that the above information is true and accurate to the best of my knowledge.

X _____

Signature of Patient or Parent if Minor

Date