Health History Form

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

Name _____**Sex** _____**Age** ____**Birthdate**_____**Date**_____

Who referred you for today's visit? __friend __relative ___other __physician (name, phone, address)

_____

What problem brings you in today? (Chief complaint)_____

Allergies to medication(s): ___ No ___ Yes (please specify) _____

Medications (please include non-prescription meds and birth control pills, write "No" if none)**:** _____

_____

Do you have any of the following? (Review of Systems) – please circle Y (yes) or N (no)

Fevers/Chills	**Y / N**	Joint Aches	**Y / N**
Recurrent mouth sores	**Y / N**	Leg Swelling (edema)	**Y / N**
Stomach (ie ulcers, acid reflux, pain)	**Y / N**	Depression or Anxiety	**Y / N**
Bowel problems (type)_____	**Y / N**	Eye problems	**Y / N**
Kidney problems (type)_____	**Y / N**	Weakness	**Y / N**
Cough	**Y / N**	Other _____	**Y / N**

Past Medical History / Family History

Disease	Yourself	Blood Relative	Disease	Yourself
Malignant Melanoma	**Y / N**	**Y / N**	HIV	**Y / N**
Other Skin Cancer			Glaucoma	**Y / N**
(type)_____	**Y / N**	**Y / N**	Cancer (type)_____	**Y / N**
Abnormal Moles	**Y / N**	**Y / N**	Hepatitis or Liver Problems	**Y / N**
(dysplastic nevi on biopsy)			(type)_____	
Psoriasis	**Y / N**	**Y / N**	High Blood Pressure	**Y / N**
Eczema	**Y / N**	**Y / N**	Pacemaker	**Y / N**
Hives	**Y / N**	**Y / N**	Mitral Valve Prolapse	**Y / N**
Allergies or Hayfever	**Y / N**	**Y / N**	Heart Valve Replacement	**Y / N**
Asthma	**Y / N**	**Y / N**	Joint Replacement	**Y / N**
Thyroid	**Y / N**	**Y / N**	(i.e. hips, knee)	
Diabetes	**Y / N**	**Y / N**	History of Blood Transfusions	**Y / N**
Arthritis	**Y / N**	**Y / N**	Seizures	**Y / N**
			Other_____	

List prior **SURGERIES** (write "No" if none):_____

*****If you are female: are you **pregnant?** □ **yes** □ no **actively trying to become pregnant?** □ **yes** □ no
breast feeding? □ **yes** □ no

Marital status:___single __married __divorced __widowed **Do you drink alcohol?** __no __yes-how often_____

Do you smoke? __no __yes-how often_____ **Occupation**_____

Patient Signature _____

Reviewed _____ Date_____
(MD Signature)

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